Tapu i te wā hapū:

Exploring the wairuatanga of Te Whare Tangata

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by

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Abstract

In Aotearoa, maternity care for wāhine Māori remains shaped by colonial legacies that separate the spiritual, cultural, and relational dimensions of birth from biomedical systems of care. This disconnection is traced and illustrates how it contributes to inequities in Māori maternal and infant outcomes, as well as intergenerational trauma that disrupts wairua and whakapapa. In contrast, empowering indigenous reproductive justice, Māori birthing and parenting traditions, alongside culturally grounded education, recognise Te Whare Tangata—the womb—as a sacred site of creation and sovereignty, where spiritual balance safeguards the wellbeing of māmā, tamaiti, and whānau.

Aim: This study explores the wairuatanga of Te Whare Tangata—the sacred house of humanity—as experienced by wāhine Māori and whānau throughout conception, birth, and the early postnatal period. It positions wairua not as abstraction but as the living force connecting whakapapa, atua, whenua, and generations. This research aims to restore visibility to these spiritual dimensions and consider how they might reshape maternity care toward balance, integrity, and mauri ora. Building on the mahi of Māori midwives and scholars before me, this thesis continues the collective effort to reclaim wairua-centred maternity care grounded in Kaupapa Māori, Mana Wāhine, and Te Tiriti o Waitangi principles.

Seven participants took part in wānanga held on a marae, drawing on maramataka, rongoā, whakawhanaungatanga, and taonga-ā-waha— including karakia, mōteatea, waiata, and pūrakau- as both method and analysis. Findings reveal that when wairua is absent, wāhine experience isolation, fear, and spiritual disconnection; when present, karakia, ūkaipōtanga, whanaungatanga, and tikanga restore tapu, mauri, and confidence in birth. Five interconnected themes emerged, positioning wairuatanga as both epistemology and praxis—a living force linking atua, whenua, and whakapapa.

This research was conducted during major structural reform, including the disestablishment of Te Aka Whai Ora, downsizing of Kahu Taurima and a growing disconnection from the founding bicultural Treaty of Aotearoa. The reforms expose the fragility of Māori-led infrastructures and the urgent need for wairua-led reform to resist further assimilation perpetuated by colonial institutions.

This thesis concludes that restoring wairua to maternity care is essential for equity, safety, and sovereignty for wāhine Māori, their whānau and the protection of the workforce. Te Whāriki o Hine-te-Iwaiwa is presented as a sacred patterned map and practical framework for whānau, midwives, and health professionals to enrich maternity and early-years care through cultural, personal, and professional development—a pathway toward an Indigenous gold standard of care defined by whānau.

Attestation of Authorship.

I, Kaniwa Tangiora Kupenga-Tamarama, hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor used artificial intelligence tools or generative artificial intelligence tools (unless it is clearly stated, and referenced, along with the purpose of use), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Karakia Tīmatanga.

Ka ranga ki runga, ka ranga ki raro, ka ranga ki waho, ka ranga ki roto, nā te mauri o Io, ki te whei ao, ki te ao mārama, kia mahea, kia watea, tihei mauri ora.

Weaving the universal essence from above, below, within and beyond, through the life force of creation, into the world of light's first dawning, into the world of full illumination. May all be healed across the threads of time — and together, we breathe life!

Ko wai au?

Ki te taha o tōku kuia rāua ko koroua, ngā pou tokomanawa o tōku ao,
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I felt so comfortable sharing the raw reality of my journey and maintaining holistic wellbeing. The reality of being a wāhine Māori, working, studying, parenting and living, can be like a novice climbing your maunga, achievable – but dependant on your support, will determine your experience.

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To all the whānau I have had the honour of caring for you, you have each taught me something about myself. The most important lesson I have learned as a public servant is that, as much as it is an honour and privilege to walk alongside anyone — especially wāhine and whānau as they grow and nurture their precious pēpi — there is an extra layer of joy when I am walking alongside my own whānau and friends on that journey. Being part of your creation story and watching your pēpi grow up is a blessing beyond words. Even to the whānau with whom I have faced challenges — I thank you for the lessons you offered. You have enabled me to reflect, to reset boundaries, and to deliver those boundaries intentionally and always with aroha.

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Chapter One: Te rangona i te karanga-o-roto | Hearing the call: When the ancestors' wildest dreams awaken — the navigator weaves their wisdom home.

This chapter opens the pōwhiri of this thesis - a ceremonial entry into the kaupapa "Tapu i te wā hapū: Exploring the wairuatanga of Te Whare Tangata". It begins with karakia to awaken connection between realms, followed by whakapapa and lived experience to locate myself as the researcher. From this foundation, the chapter sets out the purpose, aims, and questions that guide the study, positioning it within a Kaupapa Māori and Mana wāhine paradigm. It concludes by mapping both the ceremonial and structural rhythm of the thesis — from hearing the ancestral karanga to the returning of mauri to Hine-te-Iwaiwa, completing the circle of creation and return.

At the heart of this thesis lies a pressing contradiction: while Aotearoa's maternity system celebrates safety and autonomy, wāhine Māori continue to experience disproportionately poor outcomes and spiritual disconnection within clinical care. This disjunction is not accidental but the outcome of colonisation — a system that separated wairua from science, and sovereignty from birthing. To respond is to remember that wairuatanga, as embodied through Te Whare Tangata, is both the genesis and the governance of life itself.

Chapter One introduces the whakapapa, purpose, and design of this thesis. It opens the pōwhiri of this research through karakia and self-location, situating the study within Kaupapa Māori, Mana wahine, and wairua-led paradigms. This opening establishes the philosophical and spiritual foundations from which the research questions, aims, and structure unfold.

1.1 Te whakaoranga o te waimahara | Remembering through ancestral waters.

Not all karanga are heard with your ears. Some arrive as currents of knowing, knowledge drops and intuitive insights that ripple through your wairua like a spiritual glissando, shifting our frequency until life begins to rearrange around it. These are the subtle calls that open new portals of experience: the perfectly timed encounter, the chance conversation, the opportunity that would never have appeared had the vibration not changed.

For me, these calls did not come as a single revelation but as a pattern of resonance. They appeared as dreams that lingered long after waking, as tohu in the natural world, as experiences that tested my boundaries and refined my listening. A stranger's words, a patient's story, a rainbow over the marae, a phrase that echoed in my heart for weeks; each became a note within a wider composition. Together, they formed the frequency that tuned me toward this kaupapa.

When the internal karanga reverberates, it is rarely gentle. It disturbs the water and insists on transformation. For me, it came through the births I attended, the tangi I witnessed, and the moments of stillness between them, those liminal spaces where wairua speaks most clearly. It arrived through synchronicities too peculiar to dismiss, meeting mentors at unlikely times, finding myself in places where ancestral memory stirred, receiving confirmation through events that aligned too perfectly to be coincidence. These moments did not merely happen; they happened for me, each one an invitation to step closer to the spiritual heart of procreation, the role of wāhine and Midwifery itself.

As my awareness expanded, I began to understand that these experiences were not random. They were acts of whakawhiti wairua—exchanges between realms—reminding me that wairuatanga is the unseen architecture of care. The vibration of that realisation changed everything. Opportunities began to appear effortlessly: research pathways, mentors, collaborations, each unfolding in precise alignment with the timing of the kaupapa. The more I trusted those rhythms, the clearer the instructions of that karanga became.

This chapter traces that unfolding. It speaks to the inner call that drew me from the ordinary world of clinical routine into the sacred task of remembering— remembering Te Whare Tangata as a cosmological space of creation and the midwife as its guardian. What follows is both an account of lived experience and an acknowledgement of the metaphysical guidance that shapes Māori ways of knowing. It is from this awakened state of hearing that the journey toward the kaupapa begins.

This kaupapa is deeply personal and attuned to time. The conception and writing of this thesis unfolded alongside my own reproductive journey, initiated during the hapūtanga of my daughter Amaia and formally began during the hapūtanga of our pōtiki Aaliyah Vaine Ahurangi. Their births were portals into deeper layers of knowing, each infused with wairua, romiromi, rongoā, and the guidance of tūpuna. Through these experiences, the process of re-indigenizing myself became inseparable from the act of decolonising my practice. They are not only inspirations but collaborators in this work, reminding me daily that Te Whare Tangata is not theoretical—it is ancestral, lived and intergenerational.

Hine-te-Iwaiwa—the atua of childbirth, weaving, women's knowledge, and lunar tides—sits at the hearth of this thesis, guiding each creative cycle into te ao Mārama (Paringatai, 2004; Yates-Smith, 2003). Beneath the stelliform expanse of te pō, with threads in hand, the weaving begins. This is not merely an academic exercise; it is the construction of a whāriki—an ancestral mat upon which this work will rest and upon which others may one day sit in reverence, reflection, reclamation and reconnection.

The theoretical foundations are living fibres: spiritual, genealogical and political strands that carry memory, care and protest. This thesis advances an Indigenous midwifery methodology grounded in wairuatanga, whakapapa, and atua wāhine frameworks, contributing to the growing body of Māori-authored maternity scholarship.

Personally, Hine-te-Iwaiwa is not only an atua I study but a name I carry—a living connection through whakapapa and a guide I turn to in meditation, reflection, and direction. Names are portals into ancestral knowledge, memory, and dormant consciousness waiting to be reawakened. In addition to her previously named responsibilities, her realm also includes guarding the rites of passage, intuitive epigenetic wisdom embodied within our DNA, osmotically circulating through our bloodlines by her ability to pull oceanic tides and directly influence our ikura, fertility and the creative cycles of wāhine when attuned to the natural rhythms of Papatūānuku. I pronounce her name Hine-te-i-wai-wa; the feminine guardian of eternal and interdimensional waters.

Te Whare Pora is not only a space of weaving, but also a wānanga — a spiritual house of learning where knowledge, creation, and ancestral power are continually renewed (Nepe, 1991, p. 18). Known as the “house of day and night,” it teaches that learning never ends; it moves through ritual, practice, and the ordinary rhythms of life (Mead, 2016, p. 272; Te Huia et al., 2023). To live in rhythm with the maramataka is therefore to embody these same cycles—aligning body, spirit, and environment as one continuum of creation and renewal (Campbell, 2019). Like water cycling through sea, sky, and land, mātauranga flows through wāhine and whānau, sustaining generations in an endless exchange of life and wisdom (Te Huia et al., 2023). As Heke (2024) affirms, she is both the gentle hand that guides birth and the strategic mind that protects whānau and safeguards Indigenous wahinetanga.

Within Māori cosmology, Hine-te-Iwaiwa is intimately connected to fertility, protection, and the uninterrupted continuation of whakapapa (Te Huia et al., 2023). Pere (2005) describes her as a guardian honoured through karakia, where newborn girls were dedicated to her—affirming wāhine as life-bringers and kaitiaki of the spiritual thresholds. Her mana, acknowledged alongside Rongo, Haumia, and Pu-te-Hue—atua of cultivation, peace, and nourishment (Pere, 2005), anchors Te Whare Pora as a living vessel of balance, creativity and care.

While New Zealand’s midwifery philosophy emphasises partnership, protection, and participation (New Zealand College of Midwives [NZCOM], 2015), Hine-te-Iwaiwa embodies these principles at a deeper cultural and spiritual level—illuminating what partnership truly means when rooted in whakapapa and wairua. Within te ao Māori, care is not limited to clinical practice but rests on maintaining sacred relational balance between atua, whānau, and the

birthing body. As Pere (1991) articulates in Te Wheke, wellbeing is holistic, anchored in wairua, whakapapa, and the interconnectedness of all things. Similarly, Simmonds (2014) argues that atua wāhine such as Hine-te-Iwaiwa reclaims the birth space as a site of Mana wāhine, spiritual sovereignty, and cultural resurgence.

These frameworks reaffirm what many participants in this study described: that the most transformative care arises not from clinical tasks alone, but from being spiritually held, seen and woven into ceremony. In this context, Māori midwives are not simply clinicians -they are tohunga-like presences invoking karakia, anchoring mauri, and restoring the spiritual integrity of Te Whare Tangata. Their role embodies the legacy of Hine-te-Iwaiwa: midwifery as a practice of Mana Wāhine, spiritual sovereignty and cultural resurgence.

This thesis is laid down as an offering to all wāhine, women, pregnant people, their whānau, and health professionals—woven beneath the marama and guided by the constellations of Tairāwhiti—calling forth ancestral knowing and inviting the reader into both tenderness and provocation. This whāriki asks the reader to sit, listen, and feel the sacred weight of Te Whare Tangata as a site of sovereignty, healing, and intergenerational survival.

My positionality as a wāhine Māori—carrying Asian, and European bloodlines—and as a mother of Pasifika tamariki, is part of this weave: an act of reclamation and a bridge between worlds, where Kaupapa Māori epistemologies meet the lived realities of bicultural and cross-cultural navigation.

As Matua Owen Lloyd asked during the pōwhiri for our new kaimahi, Ko wai koe?—From whose waters do you come? (O. Lloyd, personal communication, 14 July 2025). Asked as part of whakawhanaungatanga, this question draws the reader into a deeper relationship with the kaupapa of this thesis—inviting reflection on identity, origin, and connection—currents that now carry us across the ātea toward the atua and ancestral threads that shape the theoretical foundations of this work. From this calling, the rangahau took root within the whenua of lived experience. The next section grounds these celestial and spiritual threads in the tangible realities of whakapapa, upbringing, and practice—locating the kaituhi within the continuum of Te Whare Tangata.

1.2 Tūrangawaewae o te kaituhi | Researcher Positionality: Weaving my story and purpose.

I did not grow up in a religious whānau, despite being baptised Anglican. I am the eldest of three daughters; my father is Māori and my mother Pākehā. I was born in Sydney, Australia, and our whānau returned to Tāmaki Mākaurau shortly after my papa passed away in early

1991. Growing up in Mangere Bridge, I had a typical Kiwi childhood — out all day on our bikes, visiting Ambury Farm, playing on the waterfront, or climbing the mountain when we weren't at each other's homes. Most summers were spent in Tairāwhiti with our whānau, surrounded by kai, wānanga, waiata and exploring our whakapapa, whenua, awa, maunga, marae, and moana. These expressions of aroha grounded me and shaped my sense of belonging.

My dad was one of the hāngi guys at our primary school gala – which always sold out. I was also a Girl Guide and took part in St John first aid classes in the evenings— perhaps these activities sparked the first embers of my calling toward healing, caring for others, and widening my social lens.

Like Aniwaniwa, there are many shades and colours within a rainbow. I am a light-skinned, green-eyed wahine Māori and Indigenously named. Throughout my mainstream schooling, I experienced moments of racism that exposed the tension between cultural identity and social acceptance. Those of us with Indigenous names know the discomfort of hearing them mispronounced; it is mana-diminishing and, at times, traumatic. Now, as an adult, I am grateful for the pūrākau and meanings behind my names — they help me stand confidently in who I am.

I share this background because I did not grow up in the first generation of kōhanga reo or within full immersion in te ao Māori. I didn't learn te reo at High school having begun Japanese at Intermediate, and although surrounded by te ao Māori through my whānau, it was not an everyday experience. I had what might be described as a "Kiwi" upbringing — where 50 cents bought spaceman lollies, $5 covered school lunch and an after-school treat, and community was woven through shared time and play.

During high school, I took an early-childhood education class that covered child development from conception to five years. Learning about fetal development captivated me so deeply that my step-grandad bought me my first (second-hand) Myles Textbook for Midwives. During a kindergarten placement, my interest in caring for others was affirmed, but at sixteen years old, the reality of supporting women through labour felt daunting – yet the seed had been planted.

When I first told my whānau I wanted to become a midwife, it caused more than a few raised eyebrows. Most of my whānau worked in education, and no one else was a midwife, so my choice seemed unusual. After my grandfather's passing, I enrolled into midwifery at nineteen, though I deferred a year to plan my path, which also led me to meet my now Husband.

During my early years of midwifery training, I experienced the profound transformation from student to māmā. Those experiences anchored me in the realities of birth, parenting, and care

in ways no textbook could teach. Midwifery became both a calling and a compass — guiding me through challenge, growth, and discovery. Learning to balance nurturing others with nurturing myself revealed that peace, stability, and spiritual connection are essential for flourishing as both māmā and practitioner.

These lived experiences have continued to inform how I understand care — as relational, cyclical, and deeply tied to wairua. They affirmed my commitment to restoring spiritual safety in maternity care and to recognise that midwifery is not only a clinical profession, but a sacred vocation rooted in whakapapa and whanaungatanga.

My first profound spiritual experience came at an Aunty's tangihanga. On the morning of her nehu, I walked toward the marae kitchen and saw a double rainbow stretching from the paddock opposite the driveway over to the paddock opposite the kitchen doors at Hiruharama Marae — a celestial archway that felt like a portal for her wairua. That moment awakened an awareness of wairuatanga I could not yet name.

The following year, I experienced an ectopic pregnancy while working as a midwife — despite having a Mirena intrauterine device insitu with a 99.9% pregnancy prevention rate. I took that pēpi home to rest beside my Aunty who had shown me the rainbow portal on the day of her nehu. Burying this pēpi with my aunty, was also the same date of my last menstrual period [LMP], forty weeks later, our second son was born. After his birth, I experienced postnatal depression, triggered by identity loss. Maternal Mental Health supported me, and I declined medication, learning instead about emotional regulation and self-care — which directly led me towards the healing modalities of the maramataka - lessons that later shaped how I supported other māmā walking through their shadows.

The following year, I cared for a woman who after her birth showed me a photo of the veins of an ovarian cyst removed early in her second trimester, which had formed her late mother's name. Moments like this deepened my conviction that wairua moves through the maternity space in ways science cannot quantify.

In 2017, I travelled to Toronto for the International Confederation of Midwives Conference and attended Indigenous workshops. Just before leaving, my papa Anaru passed away, followed soon after by my husband's nanny. Grief and travel interwove. During Papa's tangi, I whispered to him to send me one more pēpi — a girl with brown hair and green eyes. I found out I was hapū within the days after his tangi, when I had returned home. When our daughter was born thirty-nine weeks later covered in thick vernix, her appearance confirmed what I already knew — she had come through the wairua world, carried by my prayer to him.

Other experiences have affirmed my spiritual sensitivity — carrying pregnancy symptoms for a close relative until she acknowledged her own pregnancy; receiving dreams that accurately predicted a premature birth for another whānau member, and multiple pregnancy announcements within my wider whānui. Another moment of spiritual alignment occurred when I was asked to act as a postnatal midwife at a whānui gathering. I agreed, only to find that the pēpi had been born on the anniversary of my grandmother's passing and was to be raised as a whangai —who named her the same uncommon name as my own teina.

That realisation hit like a quiet surge of wairua — as though the timing, naming, and connection were orchestrated reminders that birth and death continually converse through whakapapa. These experiences remind me that the veil between worlds is thin, especially for those who work with Te Whare Tangata — that to serve in this space is to walk daily with atua and tūpuna.

Ngutu purua, the full tattooing of the lips, is not merely aesthetic. It is a sacred rite — one that signifies the voice of wāhine as bearers of karanga, ceremony, and intergenerational truth (Matata-Sipu, 2018; Dewes, 2019). As Mark Kopua (2018) explains, it symbolises the recognised authority of a woman to speak and serve on behalf of her people, embodying her role as a conduit of ancestral wisdom. Over time, ngutu purua has also come to express a deeper spiritual and social commitment - an embodied declaration of service that transcends individual identity and speaks to the collective responsibility (Kopua, 2018).

These threads of personal, professional, and spiritual experience have led me to question: In an internationally recognised maternity care system, why do inequities for wāhine Māori persist? My positionality is grounded in this inquiry — as a Māori and Pākehā midwife, māmā, and researcher committed to restoring the wairua of birth and reclaiming Māori maternal wellbeing. Through my practice and voice, I have sought to influence, advocate, and challenge those who lead and design the system — to ensure it becomes not only accessible, but uplifting and transformative for all who engage with it.

As a recipient of ngutu pūrua and moko kauae, I understand these adornments as far more than aesthetic. They are sacred rites that signify the voice of wāhine as bearers of karanga, ceremony, and intergenerational truth (Matata-Sipu, 2018; Dewes, 2019). Within my own whānau, I was among the first to receive both moko kauae and ngutu pūrua at Hiruharama Marae. My kaitā, Joni Brooking, designed my kauae around my mahi with Te Whare Tangata — a spiritual and physical expression of my responsibility to restore balance in maternity care.

These lived experiences — as a wāhine Māori, māmā, wife, midwife, and as a witness to both the beauty and pain of our maternity system — have shaped the questions that guide this

rangahau. My journey has taught me that midwifery is not only a clinical profession but a spiritual calling, one that bridges the realms of whakapapa, wairua, and the physical body. The moments of profound connection, loss, intuition, and guidance I have experienced throughout my life and practice have deepened my understanding that birth is not simply biological — it is cosmological.

Through these experiences, I came to understand that the karanga to this kaupapa was never external — it was always reverberating within. Each challenge, loss, birth, and synchronicity refined my ability to listen beyond the physical world and to recognise the sacred dialogue unfolding through everyday life. These moments were not coincidences but alignments — orchestrations of whakapapa guiding me toward remembrance. In time, I realised my wairua had been attuned to this work long before I consciously chose it. Hearing that inner karanga was both surrender and commitment: a response to the unseen call of Hine-te-Iwaiwa to bring balance back to Te Whare Tangata.

This thesis is therefore not only a piece of academic research but the continuation of that call — an offering to the ancestral vibration that first moved within me and continues to guide my practice, purpose, and being. This rangahau emerges from the space between worlds: between colonisation and reclamation, policy and whakapapa, western maternity frameworks and the sacred continuum of Te Whare Tangata.

1.3 Rangahau purpose, aim and objectives.

Purpose:

Arising from the spiritual, lived and professional experiences outlined earlier, this rangahau responds to an inner karanga — a call to explore what lies beyond the clinical landscape of maternity care. It seeks to give language and analysis to the wairua dimensions of birth that are often silenced in mainstream systems yet remain central to Māori understandings of life and creation.

The core threads of this thesis reveal a significant tension: while Aotearoa New Zealand's maternity system is positioned as reflecting global standards of best practice, it continues to produce inequitable and, at times, harmful outcomes for Indigenous wāhine. This persists despite sustained investment in forms of 'culturally safe' care that remain spiritually disconnected from Māori worldviews. These conditions are not incidental but are shaped by colonisation and its enduring systems, which fragment the human body into functional components and reduce birthing to a biomedical process.

In response, this thesis calls for a critical challenge to Aotearoa's clinically dominated maternity system and a return to recognising the inherent divinity of wāhine as kaitiaki of Te Whare Tangata. It affirms the importance of tikanga in sustaining intergenerational wellbeing within Te Ao Māori and positions Kaupapa Māori practices as a legitimate and culturally grounded skill set in the care of wāhine, pēpi, and whānau. In doing so, it also seeks to uphold the relational and holistic foundations of midwifery practice in Aotearoa, while outlining the components of a research-informed Māori midwifery toolkit.

Aim:

This study explores the wairuatanga of Te Whare Tangata — the sacred house of humanity — as experienced by wāhine Māori and whānau throughout conception, birth, and the early postnatal period. It positions wairua not as abstraction but as the living force connecting whakapapa, atua, whenua, and generations. The research aims to restore visibility to these spiritual dimensions and to consider how they might reshape maternity care toward balance, integrity, and mauri ora. Building on the mahi of Māori midwives and scholars before me, this thesis continues the collective effort to reclaim wairua-centred maternity care grounded in Kaupapa Māori, Mana wāhine, and Te Tiriti principles.

Objectives:

1. To explore the lived experiences and understandings of wairuatanga among wāhine Māori, tāne, and whānau who have engaged in the birthing process within marae, home, and hospital contexts.

2. To identify the cultural, spiritual, and relational elements that create wairua-safe care — including karakia, rongoā, maramataka, whenua-ki-te-whenua, oriori, and whānau presence — and examine how these are upheld or constrained in contemporary maternity practice.

3. To analyse how colonisation, institutionalisation, and biomedical dominance have disrupted wairua within maternity systems, tracing the historical and ongoing impacts for wāhine Māori and midwifery.

4. To interpret how Mana wāhine praxis and Te Whāriki o Hine-te-Iwaiwa can guide culturally, spiritually, and constitutionally safe maternity care models and professional education.

5. To develop recommendations for policy, workforce development, and service design that embed Kaupapa Māori principles, tino rangatiratanga, and spiritual integrity across Aotearoa's maternity system.

1.4 Rangahau questions.

Guided by Kaupapa Māori and Mana wāhine frameworks, this study is driven by a commitment to restore the wairuatanga of Te Whare Tangata — the spiritual, cultural, and constitutional integrity of Māori birthing knowledge and practice. The following questions arise from this kaupapa and form the foundation for the rangahau wānanga and subsequent analysis.

Primary rangahau question:

- How do wāhine Māori and their whānau understand, experience, and express the wairuatanga of Te Whare Tangata?

Sub-questions:

1. What are the wairua dimensions of wāhine Māori as Te Whare Tangata?
   — Exploring how hinengaro, mauri, mana, tapu, and whakapapa interconnect during conception, hapūtanga, and whānautanga.

2. How does the absence or suppression of spiritual care affect maternal and whānau experiences of birth?
   — Identifying the spiritual, emotional, and cultural impacts of colonisation, institutionalisation, and biomedical dominance on wāhine Māori and Mana wāhine.

3. What are the intergenerational consequences of spiritually disconnected birth?
   — Examining how the disruption of wairua manifests across whakapapa through trauma, silence, or embodied memory, and how reconnection can heal these imprints.

4. Why is wairua-centered practice essential for achieving equity and sovereignty in Māori maternity care?
   — Analysing how Kaupapa Māori and Mana wāhine praxis — including karakia, whānau presence, rongoā, maramataka, and marae-based wānanga — can inform system transformation and restore tino rangatiratanga for wāhine Māori, their pēpi, and whānau.

Collectively, these questions honour the sacred dialogue between theory, whakapapa, and lived experience. They guide the rangahau into the spiritual, political, and intergenerational dimensions of maternity care — ensuring that Te Whare Tangata is understood not merely as

anatomy, but as a cosmological, constitutional, and a spiritual site of creation, sovereignty, and healing.

1.5 Te Hanganga o te tuhinga | Thesis structure.

This thesis follows the rhythm of a pōwhiri — a cultural ceremonial structure that welcomes, engages, and farewells participants in sacred spaces. Each chapter represents a stage of encounter: beginning with the inner karanga of purpose, moving across the ātea of critique, sharing kai within the wharekai of methodology, entering the wharenui of analysis, and poroporaki - closing with reflection, renewal, recommendations and return. Woven throughout are the voices of whānau, wāhine, tāne, tūpuna, atua and academics — each contributing a strand to Te Whāriki o Hine-te-Iwaiwa, the spiritual and methodological foundation of this study.

The thesis is composed of five interrelated chapters, followed by a closing reflection. It is intentionally designed to guide readers through cultural, academic, maternal health, Mana wāhine, and legislative perspectives that relate to Māori maternities and the practices that enrich a pēpi's development — from conception through to their first 2000 days of life.

Discussions begun in one chapter may continue or evolve in another, sometimes offering a conclusion and at other times leaving threads open. This is not to suggest these areas are unimportant or complete; rather, like any whāriki, there are patterns woven within it — some revealed, some yet to emerge. Each reader may be drawn to different areas of detail, just as each weaver brings their own attention and intention to the work.

There are, and will continue to be, other pieces of mahi that join this one — past, present, and future — for that is the essence of wāhine: the life force connecting us to humanity, to each other, and to Papatūānuku. Following this rhythm, the next section provides an overview of each chapter — the stages of encounter within this pōwhiri that together weave Te Whāriki o Hine-te-Iwaiwa.

This thesis is also bilingual, reflecting my natural speaking voice as I continue to expand my te reo vocabulary and integrate it into daily practice. Capitalised kupu Māori appearing outside English grammatical conventions indicate a methodology, framework, legislation, organisation or kaupapa, for example; Te Whare Tangata, Te Whāriki o Hine-te-Iwaiwa, Mana Wāhine, Te Aho Matua, and Te Tiriti o Waitangi [Te Tiriti].

Kupu whakataki | Te rangona i te karanga-o-roto: Hearing the inner call and introduction to the kaupapa:

Chapter One locates me as the researcher and establishes the whakapapa of this kaupapa. It begins by laying down the turangawaewae o te kaituhi, a positionality statement tracing my lineage, upbringing, and professional pathway into midwifery. The chapter outlines the rangahau problem, purpose, aims, objectives, and rangahau questions, situating the study within the broader context of Māori maternal wellbeing and Te Tiriti. It concludes by mapping the structure of the thesis through the metaphor of a pōwhiri, guiding the reader into the sacred space of engagement.

Arotakenga whakapapa kōrero | Te ātea o Te Whāriki o Hine-te-Iwaiwa: Crossing the ancestral forecourt:

Chapter Two responds to the opening karanga, and brings us onto the ātea, where the theoretical and spiritual foundations are laid through a critical Kaupapa Māori literature review exploring the historical, cosmological, and constitutional dimensions of Māori maternity care. The review examines how colonisation, institutionalisation, and biomedical dominance disconnected wairua from maternity practice, and how Mana wāhine, wairuatanga, and Kaupapa Māori frameworks re-establish birth as a site of sovereignty and sacred ceremony. Through subchapters such as Te Whare Tangata, Ko te topenga o te taura, and Te Wakahuia o Hine, the chapter honours both the theoretical and lived reclamation of ancestral birthing knowledge, concluding by identifying key gaps addressed through this rangahau.

He ara rangahau | Te wharekai o Te Whāriki o Hine-te-Iwaiwa: Methodology and ethical pathways | The house of nourishment and preparation:

Chapter Three describes the methodological foundations and methods employed in the study. Here, we enter the wharekai — the space of nourishment — where methodology is not only the technical aspect of research but a living expression of whakawhānaungatanga and manaakitanga. It is the process through which knowledge is shared, relationships are strengthened, and the mahi itself offers sustenance — both in this metaphorical moment and for those who will continue this work. Grounded in Te Whāriki o Hine-te-Iwaiwa, the design draws upon Kaupapa Māori, Mana Wāhine, and wairua-led paradigms. The wānanga method is introduced as both a process of data collection and a living ceremony of relationship, aligning with tikanga to ensure spiritual safety, relational accountability, and collective reciprocity. The chapter explains participant selection, ethical frameworks, and the approach to thematic analysis, reflecting how theory and method are interwoven like the tukutuku panels of a wharenui.

Ngā kōrero a te whānau o Te Whare Tangata | Te whare wānanga – Findings and thematic analysis:

Chapter Four returns to the wharenui to sit with the kōrero gifted by whānau during the rangahau wānanga. Thematic analysis, conducted through Mana Wāhine and Kaupapa Māori lenses, reveals five overarching themes:

1. Te mokemoke o te wairua: Reclaiming wairuatanga in Te Whare Tangata.
2. Te iho o te ao: The sacred pulse of wāhine.
3. Te ara whakaora o Te Whare Tangata: Pathways of healing.
4. Te Whare Pora o Hine-te-Iwaiwa: Weaving sacred witnessing in midwifery.
5. Whare wānanga ki tōna marae: Reclaiming intergenerational knowledge and sovereignty.

Together, these themes form a written wānanga that centers Māori birthing sovereignty, spiritual safety, and intergenerational wellbeing.

Te otinga o Te Whāriki o Hine-te-Iwaiwa | Weaving the pathway of return:

Chapter Five closes the kaupapa, gathering the threads of analysis into a final whāriki of understanding. It interprets the findings within the wider landscape of Māori health reform, midwifery education, and Te Tiriti obligations. Ascending through te awatea — the dawn of renewal, this chapter translates wānanga into action, presenting recommendations for practice, policy, and rangahau. It outlines frameworks for spiritual safety, workforce sustainability, and wairua-led maternity care design, positioning wairuatanga, Mana Wāhine, and whakapapa as the structural logic of transformation. The chapter concludes with a call to protect the sacred continuum of life by embedding these principles into every layer of maternity care.

He kupenga kupu otinga | Closing reflection:

The thesis ends with karakia whakamutunga — words of gratitude and grounding that acknowledge the atua, tupuna, and whānau who have carried this kaupapa. It invites the reader to depart the wharenui nourished, connected, and ready to continue the intergenerational work of restoring Te Whare Tangata for those yet to come.

Chapter Two: Arotakenga whakapapa kōrero | Te ātea o Te Whāriki o Hine-te-Iwaiwa: Literature review | Crossing the ancestral forecourt.

2.1 Te karanga tuatahi | The first call, a Kaupapa Māori review of history, Te Tiriti o Waitangi, Mana wāhine, and Te Whare Tangata.

The emotional prosody of the karanga heard in Chapter One locates and positions me as an insider researcher, welcoming the reader from the metaphysical roadside gates toward the marae of this thesis. The karanga is the first voice to cross the ātea, opening cosmological dimensions, preparing the pathway for entry, and acknowledging those who carried this kaupapa before us, those who hold it now, and those yet to come (Sharman, 2019; Toki et al., 2022). Here, that voice becomes analysis: this chapter responds to the call through a Kaupapa Māori literature review of birth, wairua, and sovereignty.

Chapter Two continues the ritual, weaving scholarship and story to explore Māori maternity care as both sacred practice and site of colonisation. It examines the constitutional and spiritual foundations of Te Whare Tangata through Kaupapa Māori and Mana Wāhine frameworks, tracing how wairua was suppressed and is now being restored.

Guided by Kaupapa Māori, Mana Wāhine, and wairua-led paradigms, this chapter brings together mātauranga Māori, public health research, legislative critique, pūrākau, and the lived experiences to illuminate the continuation of whakapapa. My own journey as a Māori midwife forms part of this weave—drawn repeatedly toward the wairuatanga of Te Whare Tangata and the spiritual obligations of care.

To make sense of our sacred birthing whāriki in a contemporary context is to recognise both its ancestral and imposed fibres: harakeke once plaited into ropes strong enough to lash waka (Reilly, 2024) and navigate across Te Moana-nui-a-Kiwa via constellations with the synthetic threads of biomedicine introduced through colonisation reliant on powered nautical maps. This review therefore asks how disconnection from wairua—from hapūtanga to whānautanga and beyond —has unfolded, what its impacts have been, and how those threads are now being rewoven.

Four interconnected questions guide this review: What are the wairua dimensions of wāhine Māori as Te Whare Tangata? How does the absence of spiritual care affect maternal experience? What are the intergenerational consequences of spiritually disconnected birth? And why is wairua-centred practice essential for equity in maternal and infant wellbeing?

To answer these questions, this chapter first lays down the theoretical foundations of Kaupapa Māori, Mana Wāhine, wairuatanga, whakapapa, and Te Tiriti. These frameworks are not merely academic constructs but living ancestral threads and constitutional imperatives for protecting the tapu of Te Whare Tangata. Together, they position birth not as a biomedical procedure but as a sacred, constitutional ceremony through which whakapapa is transmitted and atua are welcomed. Te Tiriti articulates the Crown's enduring obligations to uphold Māori rights, tino rangatiratanga, and the spiritual integrity of care.

From this foundation, the review moves into Te Whare Tangata itself. It is explored not as anatomy, but as a site of cosmological power and the original whare wānanga. Wairuatanga is understood both as a lived experience and constitutional right, affirming the mauri, mana, and tapu of the womb as central to Māori and collective wellbeing. The literature reminds us that birth was once a spiritual ceremony upheld through rongoā practices such as karakia, karanga, oriori, mōteatea, waiata, romiromi, mirimiri, wairākau, kai, moko kauae, and maramataka aligned observances—and that it's disruption was a deliberate colonial act to undermine Indigenous sovereignty.

The following sections trace how colonisation, missionary conversion, institutionalisation, and biomedical dominance severed these spiritual threads and how Māori practitioners are now restoring them. Drawing on historical evidence, lived testimony, and epigenetic science, this analysis shows how disconnection from wairua leaves intergenerational imprints on body, mind, and whakapapa. Through this severing, trauma also becomes embodied in practice – especially when caring for survivors of violence, demanding deep spiritual integrity from midwives.

Finally, the review identifies key gaps in existing rangahau: the absence of explicit inquiry into wairuatanga within clinical maternity services, limited documentation of community-led birthing models that centre spiritual safety, and minimal attention to midwives' own spiritual development. These omissions are not benign — they reflect ongoing epistemic violence and disregard for Māori knowledge systems. This thesis argues that excluding wairua from maternity care is not a cultural oversight but a breach of tino rangatiratanga and Te Tiriti.

Conversely, the literature also reveals that the resurgence of spiritually anchored, whānau-led birth practices offers a constitutional, clinical, and cultural pathway forward. This review thus forms both the intellectual and wairua foundation upon which the rest of the thesis is built—including the thematic analysis of whānau kōrero in Chapter Four.

2.2 Te whāriki o te whare | The theoretical foundations: Laying the woven base | Kaupapa Māori, Mana wahine, wairuatanga and Te Tiriti o Waitangi.

Hine-te-Iwaiwa sits at the hearth of this thesis, guiding each cycle into te ao mārama. Beneath the stelliform expanse of te pō, the whāriki is laid not only as academic structure but as ceremony. These foundations are living fibres: spiritual, political and genealogical strands carrying memory and care reawakening the divine feminine through Kaupapa Māori frames guided by atua wāhine. This is both inheritance and continuation. Having prepared the ceremonial ground, the following sections introduce the theoretical threads that anchor this thesis in practice and policy.

In this chapter, Kaupapa Māori, Mana Wāhine, and wairuatanga are interwoven with a Tiriti-centred constitutional frame, where clinical, cultural, and spiritual realities are inseparable. Together they demonstrate why restoring wairua, mātauranga and tino rangatiratanga in birth is foundational to hauora and equity.

Kaupapa Māori privileges mātauranga Māori, collective analysis and tino rangatiratanga, resisting extractive Western epistemologies that fragments knowledge and reduces birth to a biomedical procedure. It is a decolonising praxis that protects Indigenous knowledge and reframes rangahau as a tool for cultural survival and self-determination (Smith, 2021; Cram, 2001; Pihama et al., 2004). As Smith (2021) reminds us, Kaupapa Māori rangahau is never neutral: it safeguards Indigenous knowledge from commodification and positions research as a waka of liberation.

Mana Wāhine stands alongside Kaupapa Māori as embodied theory and praxis. It centres wāhine Māori voices as sites of both colonisation and resistance (Mikaere, 2011; Simmonds, 2011), exposing how colonial laws and missionary values targeted Te Whare Tangata as the source of Māori continuity. By recasting birth as a clinical event under state control, colonial systems disrupted the spiritual and political authority of wāhine Māori—an act of erasure that severed whakapapa itself (Mikaere, 2011; Kenney, 2011a).

Mana Wāhine also critiques Western feminism's claims of universality, reminding that wāhine Māori navigate both colonial patriarchy and the responsibility to protect Indigenous epistemologies. It affirms that spiritual integrity and political sovereignty are intertwined; restoring one restores the other. Māori midwifery is therefore a political act of reclamation—an embodied assertion of mana motuhake over whakapapa (Campbell, 2019; Te Awekotuku, 1991; Pihama, 2001).

At the heart of these frameworks is wairuatanga — a relational dimension linking people, tupuna, atua and whenua. It is neither abstract nor religious but the spark of life connecting physical and spiritual realms (Marsden, 2003). Durie's (1998) Te Whare Tapa Whā positions wairua as one of four interdependent pillars of health; when wairua is neglected, balance collapses. Māori scholars affirm that wairua is not merely one element but the foundation that sustains all aspects of hauora (Foster, 2009; Sculley & Smith, 2023).

Whenua is the base of that whare — both land and placenta, the first connection of life. Biological research now echoes this truth, showing that the placenta is the first organ to form and mediates maternal environment across generations (Burton & Jauniaux, 2023; Sailasree et al., 2017). In Kaupapa Māori terms, this epigenetic imprint reflects whakapapa responsibility: the health of whenua shapes the health of descendants.

Across Māori and Pacific worldviews, severance from land or relationship creates illness, while ritual and collective care restore mauri (Brown, 2018; Kiyimba & Anderson, 2022). For wāhine Māori, wairua and Te Whare Tangata are inseparable (Mikaere, 2011; Tupara & Tahere, 2020). Birth is a spiritual ceremony where bloodlines and atua converge, a truth carried through karakia, oriori, and ritual (Jenkins & Mountain Harte, 2011; Ripikoi, 2015).

Such rites affirmed tamariki as he tamaiti tapu — sacred carriers of whakapapa and future potential (Rameka, 2018; Leuluai, 2018). To strip maternity care of wairua is to dismantle the foundation of Māori existence (Marsden, 2003; Mikaere, 2011; Pere, 1982).

This foundation resonates beyond Aotearoa. Federici (2004) offers a critical framework for understanding how women's bodies have long been targeted as sites of spiritual, economic, and reproductive control under early capitalism. Her analysis of epistemic violence and the suppression of women's healing knowledge provide a global context for the disconnection of wairua explored in subsequent chapters, including parallels with the European witch hunts and colonial legislation such as the Tohunga Suppression Act 1907, which ruptured Indigenous and Māori midwifery knowledges (Simmonds, 2017).

Te Tiriti is both constitutional and spiritual covenant, guaranteeing Māori tino rangatiratanga over taonga such as te reo, Te Whare Tangata, whenua, and the spiritual practices that sustain them (Orange, 2015; Waitangi Tribunal, 2014). It articulates the Crown's duty of partnership and protection, and the right of Māori to equitable health outcomes, including wairua and cultural healing (Durie, 2001).

International law strengthens this interpretation. Te Tiriti was the version debated and signed by rangatira and is recognised as the primary text. Under the United Nations Declaration on

the Rights of Indigenous Peoples [UNDRIP], Indigenous-language versions take precedence, affirming rights to self-determination, traditional healing, and spiritual relationship with land and resources (Burns et al., 2024; United Nations, 2013). Articles twenty-five and twenty-seven of The Universal Declaration of Human Rights further recognises maternal and infant wellbeing as fundamental (United Nations, 1948). Together these instruments locate wairua-centred maternity care not only as cultural imperative but as a human right.

Within Aotearoa, Te Tiriti remains both legal mandate and spiritual promise, affirming procreation as a site of sovereignty that the health system continually struggles to honour. Kidd et al. (2021) highlights persistent gaps in primary-care structures that fail to give effect to Te Tiriti, creating inequities from the earliest confirmations of pregnancy (Cram et al., 2024; PMMRC, 2024).

In midwifery, Kenney (2011b) reframes practitioners as Crown agents obligated to uphold partnership, protection, and participation. The Tūranga Kaupapa framework, developed by Ngā Māia o Aotearoa me Te Waipounamu, embeds these principles through Kaupapa Māori values and cultural safety standards (Miller and Bear, 2023). Adopted in 2008 into the Midwifery Council's cultural-safety statement and reaffirmed in 2024 Scope of Practice updates, it anchors professional conduct to Te Tiriti (Midwifery Council of New Zealand, 2024a, b, c).

These developments signal genuine movement toward a Te Tiriti-honouring workforce—one that centres Māori leadership, shares resources equitably, and dismantles colonial hierarchies within health governance (Te Hiringa Hauora, 2021). Yet achieving this vision requires more than policy; it demands sustained decolonisation of health regulation and education.

A post-colonial lens exposes how colonial power continues to reproduce itself in health policy (Smith, 2021; Walker et al., 2006). Rae et al. (2023) found that Te Pae Tata: The Interim New Zealand Health Plan engaged tino rangatiratanga and kāwanatanga only "fairly" and wairuatanga "poorly." Hamley et al. (2023) argue that such omissions render Te Tiriti commitments performative, whilst maintaining structural inequities. In maternity care, this becomes spiritual erasure: when wairua is excluded, birth is legislated as purely biomedical. Restoring balance requires Māori-led models where wairua is central, not symbolic.

This marginalisation is historically patterned, not accidental. Legislation such as the Midwives Act 1904 and its UK counterpart (1902) imposed state control, delegitimising Māori midwifery and criminalising ancestral knowledge (Reid et al., 2014; Tawhai & Gray-Sharp, 2011). Similar

laws across the Commonwealth reveal a coordinated project of epistemicide—erasing women's healing authority to consolidate biomedical dominance (Reid, 2017).

During the early modern period across Europe and its colonies, women were systematically excluded from the healing sciences—including midwifery—as part of a broader colonial and patriarchal restructuring of knowledge and power (Chauhan, 2005; Ehrenreich & English, 2010; Whaley, 2011). Women healers, often midwives or herbalists, held significant mana as kaitiaki of life, procreation, wairua and community wellbeing (Brice, 2020; Whaley, 2011). Their exclusion formed part of a calculated campaign to dismantle traditional, spiritual and empirical healing systems, replacing them with male-dominated, institutionally sanctioned medicine (Amponsah, 2011; Bartolo, 2024; Chauhan, 2005; Ehrenreich & English, 2010; Federici, 2004; Whaley, 2008, 2011).

These women were criminalised and vilified—many in Europe burned as witches not for causing harm but for healing without church approval, assisting fertility, or embodying female agency (Chauhan, 2005; Ehrenreich & English, 2010; Federici, 2004). The witch trials were deliberate state and church-led campaigns of social control, early expressions of epistemic violence that dismantled women's knowledge and spiritual authority to consolidate elite male power over life and death (Chauhan, 2005; Federici, 2004; Whaley, 2008; Ehrenreich & English, 2010). Bartolo (2024) further highlights how midwives' alleged failures were politicised to justify their exclusion from medicine.

For Māori, these echoes are deeply familiar. The global assault on women's healing knowledge resonates with the suppression of Te Whare Tangata under colonisation (Meredith, 2024; Mikaere, 2011; Simmonds, 2011). It is not merely the biomedicalisation of birth that we resist—but the intergenerational trauma of having our atua, wairua, and tikanga discredited in service of western hegemony (Marsden, 2003; Meredith, 2024; Pihama, 2001). This suppression was codified through the Tohunga Suppression Act 1907, which criminalised Māori spiritual and healing expertise (Kolo, 2024).

Introduced under Richard Seddon's administration, the Tohunga Suppression Act 1907 was not about curbing "charlatanism" but, as Hansen (2022) makes clear, "was all about suppression" — a necropolitical artefact designed to curtail Māori leadership and tohungatanga. It created a climate of fear and silenced cultural knowledge (Orange, 2015). Although repealed through the Māori Community Development Act 1962, the damage endured—seared by fear, scarred through silence, and fused with the institutionalisation of birth. Reclaiming tohungatanga in midwifery today is not nostalgia; it is resistance to colonial warfare against the womb.

Recent policy cycles echo that fragility. The creation of Te Aka Whai Ora under the Pae Ora (Healthy Futures) Act 2022 marked historic recognition of Māori health governance, yet its 2024 disestablishment re-exposed the vulnerability of Indigenous gains. The Waitangi Tribunal (2024) deemed the repeal a breach of Te Tiriti, and Māori health leaders condemned it as reassertion of colonial control (Came et al., 2024; Hei Āhuru Mōwai, 2024). As Turei (2025) observes, the very reforms designed to embody Māori–Crown partnership — such as Te Aka Whai Ora — became "political weapons used against the government and Māori," revealing how fragile Indigenous rights remain when constrained within Crown-determined frameworks. Until tino rangatiratanga is constitutionally embedded, Māori wellbeing will remain contingent on political will.

Contemporary health data make this clear. The Lancet Oncology (2021) reported wāhine Māori are a third less likely to access cervical screening yet twice as likely to die from cervical cancer—evidence that inequity is structural, not behavioural. The PMMRC (2024) similarly finds wāhine and pēpi Māori disproportionately represented in preventable perinatal deaths, with leading causes including prematurity, respiratory illness, Sudden Unexplained Death in Infancy [SUDI], and suicide. Only 58.4% of wāhine Māori secure a Lead Maternity Carer in the first trimester, despite representing 25% of all birthing parents (Te Whatu Ora, 2024a). These outcomes are living manifestations of Treaty breach and colonial neglect.

Yet within these inequities lies endurance. Wāhine Māori achieve higher spontaneous vaginal birth rates than national averages (Te Whatu Ora, 2024b, 2024c), reflecting the intergenerational transmission strength and continuity of Indigenous birthing knowledge within colonised systems. Breastfeeding and ūkaipōtanga similarly express reproductive sovereignty, carrying whakapapa, strengthening whānau bonds, nourishing with rongoā, and nurturing wairua.

Exclusive waiū rates for Māori babies are higher than national averages in the early weeks, reflecting the relational strength of Kaupapa Māori maternal care and culturally safe midwifery support (New Zealand Breastfeeding Alliance, 2024; Te Whatu Ora, 2024d, 2024e). However, these rates decline sharply by three months postpartum, revealing the structural vulnerability that emerges once this support ends (Edwards, 2014; Reinfelds, 2015).

The concept of ūkaipōtanga positions breastfeeding as a holistic continuum—spanning physical, cultural, and spiritual dimensions—and emphasises the need for sustained whānau-centred care (Edwards, 2014). The Tiakina Te Ūkaipō framework further identifies the trusted whānau–midwife relationship as central to maintaining the mother–infant dyad and nurturing confidence beyond the early weeks (Reinfelds, 2015). When that relationship is disrupted,

breastfeeding momentum falters, not from individual failure but from systemic inequities that erode continuity of care. As Mikaere (1995) argues, colonisation destroyed the spiritual and social balance of Māori society, displacing wāhine from positions of reproductive authority. These colonial attitudes extended into maternity care, shaping intergenerational attitudes toward wahine Māori breastfeeding and eroding tikanga such as shared feeding, co-sleeping, and whānau-based care (Gabel, 2019; Reinfelds, 2025; Simmonds, 2017). Protecting these tikanga through long-term, whānau ora–based support for Te Whare Tangata is therefore both clinical necessity and act of tino rangatiratanga.

For Māori midwives, these frameworks are lived daily. As Tupara and Tahere (2020) observe, they must embody indigeneity while navigating colonial systems — translators, advocates, and protectors of Te Whare Tangata in under-resourced environments. Despite these pressures, momentum is building, cultural safety is a legal requirement under the Health Practitioner Competency Assurance Act 2003, aligning practice with Treaty obligations and affirming wairua as a dimension of professional competence (Midwifery Council of New Zealand, 2024b).

By making cultural safety a legal and professional requirement, the system begins to align with Te Tiriti obligations, recognising that care for wāhine and pēpi Māori must centre Kaupapa Māori and wairuatanga. This is not merely professional development; it is a commitment to dismantling inequities and to upholding Indigenous self-determination in birth—consistent with the International Confederation of Midwives (2021) partnership between Indigenous and non-Indigenous Midwives statement, which links sexual, reproductive, maternal, neonatal and adolescent health inequities to colonisation, and calls for equitable partnerships with Indigenous communities, recognition of Indigenous midwives' autonomy and governance, cultural safety education across the sector, and the legal recognition and funding of Indigenous midwives educated and regulated to their own community standards; it also notes that Indigenous midwifery services offer culturally safe, community based care associated with improved outcomes for birther's and babies, particularly in marginalised communities.

At the centre of these foundations is Te Whare Tangata. More than anatomy, it is a cosmological and political site, carrying the mana of future generations and the spiritual threads of whakapapa (Kenney, 2011a; Mikaere, 2011; Tupara & Tahere, 2020). To honour Te Whare Tangata is to honour Te Tiriti, wairuatanga, and Mana Wāhine simultaneously. Together, Kaupapa Māori, Mana Wāhine, wairuatanga, and a Tiriti-centred constitutional frame are not separate theories but interwoven fibres of the same whāriki – a philosophy of balance between body, spirit and sovereignty.

In this convergence of policy and spirituality, the message is clear: wairua is not peripheral to health — it is constitutional. The midwife who honours wairua honours Te Tiriti, restoring the balance between body and spirit, people and atua. This subchapter answers rangahau questions one and four, establishing the theoretical ground for wairua-centred, Tiriti-honouring maternity care. With the whāriki wrapped around us, the pōwhiri carries us forward — the kaikaranga calls, summoning us toward the ātea, where the spiritual dimensions of Te Whare Tangata await revelation.

2.3 Te Whare Tangata: Ko te karanga, ko te kāinga, ko te ara wairua: The call, the home, and the spiritual pathway – entering the cosmological house.

Crossing the ātea, we enter te ara wairua — the sacred pathway into our creation stories. This section explores the spiritual and cosmological dimensions of Te Whare Tangata and why wairua awareness is vital to restoring hauora. Where 2.2 laid the conceptual ground, 2.3 moves into embodiment — recognising Te Whare Tangata as a cosmological portal, a locus of wairua sovereignty and meeting place of atua and whakapapa. As wāhine, moving across the ātea, we have the ability to whakanoa the spaces we inhabit. To understand this power, we must revisit how and remind ourselves why.

To speak of Te Whare Tangata is to enter sacred conversation, approached through intuition and reverence. Knowledge arises through the hinengaro, the inner realm of knowing. Marsden (2003) calls the whatumanawa the spiritual organ of perception, the doorway to wairua, while Pere (1982) affirms emotional and spiritual perception as valid knowledge. Forster (2022) extends this, describing hinengaro as the space where cosmic insight is received and embodied- making the invisible, visible through values and relationships. Here we encounter the interwoven threads of mana, mauri, and wairua that connect atua, whenua, and whakapapa. Mauri animates their union and heightens during hapūtanga, when Te Whare Tangata becomes a vessel for intergenerational vitality (Mead, 2016; Semmons, 2006).

Māori understands the human being as guided by ngākau and ngako—spiritual and emotional centers of wellbeing. Within this framework lie three sacred hearts gifted by atua: the whatumanawa, seat of emotional and spiritual heart (Marsden, 2003; Pere, 1991); the manawa, physical heart linked to hinengaro and vitality (Mead, 2016); and the pūmanawa in the lower puku, intuitive core of ancestral creativity (Mead, 2016; Pere, 1991). Rameka (2015) shows that from conception, spiritual and physical fusion begins—te ira atua, the divine spark—marking the sacred origin of pēpi. Fox (2025b) situates whatumanawa and pūmanawa as key domains of Indigenous intuition and inner knowing.

Te Aho Matua, both philosophical foundation and legislated curriculum of Kura Kaupapa Māori, names these hearts as “spirit receptor-transmitters of whatumanawa, hinengaro, auaha, ngākau, and pūmanawa; the iho matua—the umbilical cord of spiritual energy” (Te Rūnanga Nui o Ngā Kura Kaupapa Māori o Aotearoa [TRNoNKKMoA], 2008). Originally articulated by Kāterina Mataira, with Tuki Nepe and Cathy Dewes, as part of the 1989 Kura Kaupapa Māori Working Party, Te Aho Matua grounds the kaupapa of Māori education in wairua and whakapapa (Tocker, 2015). It details the child as inherently spiritual, connected through whakapapa to atua and the cosmos (Heaton, 2018). Gazetted in 2008, it embeds these principles structurally in Māori education. Dixon (2013) offers a parallel in midwifery, describing wairua, hinengaro, and tinana as an integrated whole—an alignment essential for deep listening and spiritual integrity.

During hapūtanga, these sacred hearts within wāhine are heightened as tōhua become instruments of communication, exchanging sacred knowledge during descent from Rangi Tūhāhā to Papatūānuku (Fox, 2025b; Marsden, 2003; Pere, 1991; Rameka, 2015). Qualitative studies of first pregnancies echo this intensification, describing profound transformation—revisioning of self, relationships, and purpose (Messias & DeJoseph, 2007). Rameka (2015) explains that pēpi remain close to te ao wairua from conception, carrying ancestral connection into te ao mārama, aligning with Marsden’s (2003) view that the human is a spirit with a body. Kolo (2024) highlights birthing traditions—karakia, oriori, taonga pūoro, and whenua-ki-te-whenua—that invoke atua, are to guide and protect māmā and pēpi.

The sacredness of tamariki as ira atua is inseparable from that of the vessels that carry them. The divine spark confirms the enduring mana in all life, yet wāhine, as custodians of Te Whare Tangata, elevate this mana through their role as portals between realms - a truth reflected in Māori cosmology, where ira atua and mauri unite within the womb, binding spiritual and physical creation (Marsden, 2003; Mead, 2016; Rameka, 2015). Mikaere (2011) explains that Māori understandings of procreation place wāhine at the centre of cultural and spiritual authority, while Pihama (2001) affirms this authority as Mana Wāhine. To honour the sanctity of tamariki is therefore to honour wāhine as bearers of whakapapa and kaitiaki of cosmological continuity.

With the three sacred hearts in alignment, we turn to karakia as a way of seeking permission — not only from external sources but from within. Ripikoi (2015) explains that access to wairua occurs through tikanga such as karakia, karanga, raranga, and waiata — rituals reconnecting wāhine to te ao Māori and confirming the spiritual nature of wellbeing. Dixon (2013) likewise identifies these practices as foundations for spiritual reconnection and intentional engagement

with wairua-led knowledge. Guided by hinengaro, the intuitive mind, we first seek consent to speak of Te Whare Tangata and to receive the mātauranga tapu revealed.

This is not theoretical but lived and felt — a spiritual exploration of honouring and protecting the pathways of procreation, whakapapa, and cosmological emergence. Ripikoi (2015) illustrates that a Kaupapa Māori approach to wairua restores wellbeing and cultural integrity among wāhine Māori. Such knowledge, carried through practice, intuition, and ancestral memory, restores mana to whānau, reconnects us with atua, and reawakens the dignity and divinity of birth.

Yates-Smith (2003, 2006) shows that wāhine embody both Te Whare Tangata and Te Whare Aituā — a cosmological pairing positioning them within life and death's continuum. The womb is gifted through Hineahuone from Papatūānuku, and at death the body returns to te kōpu o Papatūānuku while the wairua is received by Hine-nui-te-pō. Gabel (2013) endorses this maternal authority, underscoring Te Whare Tangata as sacred power. In this dual embodiment, wāhine stand as navigators between realms, vessels of celestial wisdom through whom hinengaro bridges atua and whakapapa (Forster, 2022).

To birth in Māori ways is to enact Mana Wāhine and atua-led sovereignty, transferring whakapapa ritually from one realm to another (Mikaere, 2011; Sharman, 2019). Te Whare Tangata is a cosmological portal where atua and whakapapa coalesce (Reinfelds, 2015). The disruption of these practices through colonial medicine was not merely a clinical intervention but a form of spiritual dismemberment — a process Skerrett (2022) describes as the colonial severance of Māori cosmology from its spiritual and gendered balance, replacing sacred relationality with patriarchal materialism. Reclaiming karakia, whenua-ki-te-whenua, and atua-led birthing reactivates Indigenous constitutional authority embodied in the māmā (Sharman, 2019). August (2004) affirms Te Whare Tangata as the sacred threshold where atua, whenua, and whakapapa converge through ritual and ceremony in menstruation and birth. These rites positioned wāhine Māori as vessels of life and conduits of intergenerational connection.

Murphy (2019) expands this through the revitalisation of Te Awa Atua, describing menstrual flow as whakapapa embodied in divine rhythm. Its suppression under colonisation deliberately dismantled the spiritual authority of wāhine Māori, making its restoration an act of decolonial reclamation. Grounded in Mana Wāhine, this reasserts Te Whare Tangata as a site of spiritual, sexual, and constitutional authority. Skerrett (2022) adds that colonial systems distorted Māori cosmology and gender dynamics, recasting wāhine as spiritually diminished. Reclaiming mātauranga ūkaipō, ritual, and wairua-led midwifery is thus epistemic justice, affirming wāhine

as guardians of whenua and weavers of whakapapa continuity (Mikaere, 2017; Murphy, 2019; Pihama, 2001).

Murphy (2014, 2019) situates ikura within the sacred rhythms of the moon and atua wāhine. In this cosmology, ikura is a sacred river reflecting the waxing and waning of Hine-te-Iwaiwa. Colonial Christianity reframed this blood as pollutant, severing wāhine from embodied cosmological power (Mikaere, 2017). Murphy (2014) confirms that birth rites are blood rites; reclaiming ikura as ceremony restores Mana wāhine and reaffirms Te Whare Tangata as a sovereign site.

These cycles align with the maramataka. Matamua (2017) explains that the Māori year began not under Whiro, the 'dangerous' new moon, but with Rākaunui, the full moon of fertility and abundance (Tāwhai, 2019), echoed in Tangaroa phases of productivity. This lunar logic situated menstruation, ovulation, and fertility within a celestial order — a view shared across Indigenous nations where moon time ceremonies honour menstruation as renewal and reciprocity with the land (Gaudet & Caron-Bourbonnais, 2015; Savage, 2025). Contemporary science complements these traditions: lunar rhythms influence melatonin, circadian cycles, and labour timing (Bevington, 2015; Matsumoto & Shirahashi, 2020). Within this cosmology, ikura is a tohu of whakapapa, an ancestral life force and sign of future possibility (Wairoa, 2024, as cited in Re:News, 2024).

As sacred rhythm, ikura carries mana, mauri, and protective tapu (McAllister, 2021). Ngāpō and Kingi (2024) describe mauri as a continuum flowing through menstruation, conception, and hapūtanga — cyclic energy sustaining Te Whare Tangata as a portal of creation. Yet, as Mikaere (2017) argues, colonisation undermined this spiritual and constitutional authority. Restoring the mana of Te Whare Tangata is therefore a restoration of balance, sovereignty and collective wellbeing.

Hapūtanga itself was understood as te whare wānanga—a sacred school of learning where body and spirit are nurtured in unison (Barrett et al., 2023; Heke, 2021; TRNoNKKMoA, 2008). Renowned Rongoā practitioner Awhitia Mihaere teaches that the unborn child is engaged in wānanga with Io; if the child chooses not to transition to earth, it is not maternal failure but a divine decision to return to Rehua, celestial guardian of the twelfth realm (Toi Tangata, 2022). In this framing, miscarriage and stillbirth are cosmic transitions rather than medical pathologies, underlining Te Whare Tangata as a threshold between realms where divine law is enacted. When pēpi pass after birth, their wairua follows the ancestral pathways of return—lingering through tangihanga before journeying onto te rerenga wairua, always within care and guidance from whakapapa (Clarke & McCreanor, 2006; Jacob, 2011).

These principles of guardianship, continuity, and wairuatanga are embodied in rongoā Māori—a holistic healing system grounded in spirit and lived experience. Modalities such as karakia, matakite, rongoā rākau, wai, pure, mirimiri, romiromi, and taonga pūoro sustain mauri and mana (Ahuriri-Driscoll, 2014). Rangahau demonstrates that engagement with rongoā enhances spiritual, social, and psychological wellbeing, with measurable gains in te taha wairua and te taha whānau (Keats-Farr, 2022). Within this thesis, rongoā is understood as the practice that maintains balance within Te Whare Tangata.

Despite its whakapapa-based authority, rongoā is often marginalised as "complementary medicine" (Mark, 2012; Waitangi Tribunal, 2011). The NZCOM (2018) classification reflects lingering colonial hierarchies that contradict the Midwifery Council's (2024a) Scope of Practice, which embeds Te Tiriti and the valuing of mātauranga Māori—a contradiction explored further in 2.4.

Recent shifts offer hope. Since 2020, the Accident Compensation Corporation [ACC] has funded rongoā Māori for injury recovery, with over 226 practitioners delivering 121,000 sessions by 2024, with approximately 40% of sessions to non-Māori (ACC, 2025b). ACC (2025a) now includes rongoā as rehabilitation for maternal birth injuries. In Tairāwhiti, Koka Awhitia Mihaere and I co-supervised a Rongoā practitioner within Nāti Pēpi to gain ACC accreditation, ensuring hapū māmā could access mirimiri as part of holistic birth preparation and postnatal recovery. Nāti Pēpi's ACC-registered Rongoā practitioner provide mirimiri, romiromi, and holistic healing within hapūtanga and post-birth wānanga, affirming rongoā Māori as an integral, kaupapa-aligned component of maternity care (Health Point, 2025; Ngati Porou Oranga, n.d.). These developments confirm the institutional and cultural legitimacy of rongoā Māori as a pathway to maternal healing and wellbeing.

Across five pregnancies I lived with pubic-symphysis disorder. At a 2017 Ngā Māia ki Tāmaki Makaurau wānanga I received mirimiri and my pelvis stabilised instantly; the pain resolved, and I completed the final eight weeks pain-free. That labour was the most healing of all. Rangahau affirms these effects: mirimiri supports physical, emotional, and spiritual balance (Gemmell, 2020; Gregg et al., 2006). More than therapy, mirimiri realigns body and spirit, preparing Te Whare Tangata for the sacred transition of birth. Through touch and karakia, hinengaro bridges atua and whakapapa, so māmā and pēpi heal together (Ahuriri-Driscoll, 2014; Haimona, 2025).

Within rongoā Māori, maramataka provides rhythm—aligning care with lunar and environmental cycles (Hikuroa, 2017; Warbrick et al., 2023). It calibrates activity and rest to atua phases: high-energy work under Rākaunui, gentler rituals during Whiro (Tāwhai, 2019).

These rhythms mirror evidence linking lunar-circadian patterns to physiology and mood (Fox & Enari, 2025a; Warbrick et al., 2023). Because each iwi localises timing to whenua and season (Hikuroa, 2017), maramataka is both a spiritual and practical tool for interpreting tohu, managing stress, and sustaining mauritau (Angeli-Gordon, 2024; Roberts et al., 2006). Viewed this way, maramataka is rongoā in time, re-centering Te Whare Tangata within local Indigenous rhythms that protect the mauri of hapūtanga (Matamua, 2020).

Emerging rangahau affirms these benefits. Wāhine practitioners describe rongoā as transformative across physical, emotional, and spiritual domains but emphasise the need for tikanga-grounded training (Haimona, 2025). Prevalence of use continues to grow alongside evidence of wellbeing gains (Keats-Farr, 2022; Whangapirita, 2003). Within hapūtanga, rongoā is not “complementary care” but an enactment of Mana Wāhine and atua-led sovereignty, preparing the way for connected practices—karakia, karanga, waiata, and oriori. In this sense, rongoā is embodied wairua, and oriori its extension through voice—one flowing naturally into the other.

Gabel (2013) explains that oriori were sung from the earliest stages of life — sometimes directly to the puku during hapūtanga or onto the child’s pūmotomoto after birth — embedding tribal histories, whakapapa, and ancestral expectations into the child’s consciousness. Papa Amster Reedy taught that oriori tells a child “where they come from … and the journey that lies ahead” (Waka Huia, 2011a). These songs supported the māmā while transmitting identity to the tōhua. Papa Amster recalled being invited to births to recite oriori, noting that the unborn would kick in response and that recitation during labour calmed the hapū māmā (Waka Huia, 2011a, 2011b). This aligns with Roestenburg’s (2020) concept of ihirangaranga — the sacred vibration of ancestral sound imprinting wairua and mauri on the unborn — and with karakia as vibrational science within te ao Māori (Barlow, 1991; Pere, 1991).

This reflects a worldview where the child is inherently divine, and the womb is a portal of spiritual preparation and ancestral activation (Pere, 1991; Rostenburg, 2020). Tibble-Pou (2022) affirms that oriori acts as rongoā, healing intergenerational trauma and restoring spiritual presence between māmā and pēpi. Within traditional Māori parenting, tamariki were nurtured through collective care, spiritual responsibility, and inherited aroha (Graham, 2018). The Taku Waipiataata, Taku Hei Tāwhiri report reiterates that Māori parenting was cosmologically anchored: children recognised as atua in human form, imbued with mana, mauri, and tapu from conception (Angeli-Gordon, 2025).

Aotearoa New Zealand’s Child and Youth Strategy 2024–2027 identifies the first 2000 days as critical for lifelong wellbeing (Ministry of Social Development, 2024). Midwives are uniquely

positioned to foster maternal-infant attachment through culturally grounded practices (Stoodley et al., 2023). One such practice is maternal singing; controlled trials show lullabies improve bonding, reduce stress, and lower infant colic (Persico et al., 2017). Oriori function similarly as a tikanga-based “spiritual curriculum” nurturing belonging, identity, and whakapapa, using emotional prosody to engage hinengaro, uplift wairua, and harmonise body and spirit (TRNoNKKMoA, 2008).

Contemporary neuroscience converges with this wisdom. Daily prenatal music exposure strengthens newborn brain responses to tone, supporting early pitch and language development (Arenillas-Alcón et al., 2023). Neonates are sensitive to emotional prosody from birth, decoding affective tone even while asleep (Zhang et al., 2014). Maternal prosody shapes attachment and emotional growth (Larrouy-Maestri et al., 2024). Oriori therefore embodies what science now confirms: sound, rhythm, and song are ancestral tools of imprinting pathways shaping attachment, neural development, and spiritual flourishing.

Papa Amster emphasised that oriori modelled non-violent parenting: “I have never found in these oriori how to punish or smack children” (Waka Huia, 2011b). This aligns with Angeli-Gordon’s (2025) description of intuitive Māori child-rearing, where karakia, waiata, mirimiri, and collective attunement uphold the child’s mauri and mana. Across generations, oriori offer a relational blueprint for whānau as kaitiaki wairua, reaffirming wāhine Māori as cosmological leaders and embedding the collective spiritual responsibilities in each child’s growth.

Papa Amster warned: “If our traditional birthing and child-rearing practices disappear — so will Māori” (Waka Huia, 2011b). Oriori are not relics but living transmissions of whakapapa, sovereignty, and survival tools restoring Māori wellbeing and ensuring sacred continuity (Angeli-Gordon, 2025). A Kaupapa Māori approach frames hapūtanga and birth as rites of passage requiring spiritual accompaniment, collective care, and ethical responsibility (Te Huia, 2020).

Awhitia reminds us that the midwife’s role is also to strengthen the māmā spiritually so she may guide her whānau—including her partner’s—through birth (Toi Tangata, 2022). Midwives who centre wairuatanga are not only clinicians but kaitiaki, shaping relational, ceremonial, and environmental conditions that uphold the mana of Te Whare Tangata. Their responsibilities extend beyond procedures to spiritual, emotional, and cultural guidance grounded in tikanga (Simmonds, 2016; Te Huia, 2020; Tupara & Tahere, 2020).

In many whānau, wāhine remain the primary carriers of mātauranga while others continue recovering from knowledge rupture. Historically, they were cultural leaders and protectors of

mātauranga wāhine, stewarding intergenerational transmission (Heke, 2021; Simmonds, 2016). Such transmission requires time, safety, and collective readiness. Latham (2020) likens reclaiming tikanga in pregnancy and birth to “the umbilical cord to your past and your future,” reconnecting whānau to whakapapa and countering disconnection. Culturally safe, well-resourced spaces are therefore essential to protect wairua and enable whānau participation (Simmonds, 2016).

This work becomes hardest when survival needs dominate—when safety and cost of living eclipse spiritual growth. From a Kaupapa Māori view, this is not merely a health issue but a structural one, rooted in the political-economic dismantling of Māori systems of care (Dawson et al., 2019; Simmonds, 2016). Taku Waipiataata, Taku Hei Tāwhiri functions not only as a parenting model but as a strategy for whānau transformation grounded in wairua, Mana Wāhine, and whakapapa sovereignty (Angeli-Gordon, 2025).

In te ao Māori, wairuatanga is neither a metaphor nor emotion but a cosmological, intergenerational reality. Kiyimba and Anderson (2022) explain that wairua is not private or abstract; it emerges through relational presence. In their Māori and Pasifika mental health rangahau, they define wairua as the felt space between people, tupuna, atua, and place. When honoured in care settings, it becomes a grounding force for healing and reconnection (Kiyimba & Anderson, 2022). Pere (1991) and Durie (2006), uphold wairuatanga as an essential and non-negotiable foundation of holistic wellbeing that must be restored in maternity care if Te Tiriti promises are to be fulfilled.

The case for spiritually accompanied whānau-held maternity care is forward facing. Stats NZ (2025) reports Māori comprise about 17% of the population and, with a youthful age structure, wāhine Māori account for roughly one-quarter of births (Health New Zealand [HNZ], 2025)—a proportion likely to sustain demand for Kaupapa Māori pathways for decades. The message is clear: wairuatanga must be centered in maternity care, collective obligations across whānau, hapū, and iwi rebuilt, and the mental and spiritual wellbeing of māmā upheld amid structural pressures.

In practice, this means tikanga anchored care—karakia woven into clinical encounters, group pathways fostering whanaungatanga and kotahitanga, and whānau centered practice as a determinant of cultural and clinical safety (Meredith, 2024). With suicide being the leading cause of maternal death in Aotearoa, and Māori affected at nearly three times the rate of New Zealand European mother’s, these approaches must be trauma informed and address the colonial and structural determinants of perinatal inequity (Meredith, 2024).

Together, these insights respond to rangahau questions one and four, affirming that the wairua of Te Whare Tangata is both lived experience and constitutional right - essential to restoring hauora. They also gesture toward rangahau questions two and three, taken up in sub-chapter 2.4 and Chapter Four, where institutional ruptures and disconnections of wairua are traced.

Crossing the ātea with Te Whāriki o Hine-te-Iwaiwa, we now sit to connect with one another. Before we begin, we air the whāriki and state our purpose. What follows is the testing ground—where Tāwhirimatea's winds meet Tūmatauenga's domain, straining the weave against forces that seek to undo it.

2.4 Ko te topenga o te taura | Tracing the disconnection of wairua: The severed cord – naming colonial ruptures in Māori maternity care.

Entering this ātea, the winds rise, clutching Te Whāriki o Hine-te-Iwaiwa as its fibres are pulled and torn. The gusts expose fragile gaps where the cold cuts through—revealing that we can no longer cling to unsustainable practices that have reshaped how we nurture whenua, Te Whare Tangata, tamariki, and whānau. This subchapter names these disruptions—moments where the sacred weave of the whāriki has been obscured or rewoven by colonial systems. Tracing the frayed lines, we see the breaches from which restoration must begin. What follows maps the historical unravelling of spiritual and material sovereignty in childbirth—from the suppression of tohunga to the bureaucratisation of motherhood.

Colonisation, institutionalisation, and the suppression of Indigenous birthing knowledge unravelled the sacred threads of maternity. Drawing on pūrākau, Mana Wāhine theory, legislative critique, and qualitative rangahau, this section traces how te taura here wairua — the spiritual cord binding atua, tupuna, whenua, and whānau — was severed. In maternity, this cord finds its clearest expression in the whakapapa line transmitted through Te Whare Tangata. When honoured, Māori thrive; when desecrated, trauma reverberates across generations. Embodied intuition is central here, affirmed in both mātauranga Māori and global midwifery epistemologies (Gaskin, 1996; Gould, 2017; Sargent & Bascope, 1996; Vinaver, 2023). This establishes the analytical frame that follows.

Colonisation was not only a political-economic project but a profound spiritual rupture that destabilised the cosmological, social, and physical systems sustaining Māori life (Bellingham, 2021; Mikaere, 2011; Marsden, 2003). Birthing had long been governed by tikanga integrating physical and metaphysical wellbeing (Kenney, 2011; Papakura, 1938), and occurred in purpose-built whare kōhanga— secluded spaces of heightened tapu designed for balance and protection (Best, 1975; Clarke, 2012). Within them, tohunga led karakia, mirimiri, and

invocations of atua wāhine such as Hine-te-Iwaiwa, ensuring wairua, whakapapa, and the safety of māmā and pēpi (Kenney, 2011; Marsden, 2003).

After birth, the whare kōhanga was ritually cleansed to restore balance between tapu and noa (Best, 1975; Kenney, 2011). The whenua and iho were returned to Papatūānuku through whenua-ki-te-whenua, sustaining identity across generations (Rameka et al., 2023). These practices were not symbolic embellishments but cosmological laws maintaining birth as spiritual sovereignty. From this locus, the ensuing ruptures are best understood.

This sovereignty was steadily eroded. Christian conversion and missionary influence reframed childbirth through a Western biomedical lens, undermining the authority of tohunga (Jenkins & Matthews, 1998; Kenney, 2011). Colonial law and hospital regulation then reinforced this shift, embedding biomedical dominance within Māori maternity care. As August (2004) and Mikaere (2011) explain, such frameworks dismantled the Indigenous systems that had long safeguarded maternal and infant wellbeing. Lawrie et al. (2024) describe how these policies dismantled birthing positions, rituals, and whānau involvement, stripping wāhine Māori of bodily autonomy, spiritual safety, and the ability to enact tikanga in clinical spaces. In short, ritual was replaced by regulation.

Even small breaches deepened this rupture. European practitioners entering sacred spaces from the wrong side, interrupting karakia, or disregarding tapu were not lapses in etiquette but violations of tino rangatiratanga and spiritual authority in childbirth (Clarke, 2012). These acts fractured the balance between wairua, whakapapa, tapu and noa – principles essential to the safety of māmā and pēpi (Clarke, 2012; Kenney, 2011; Marsden, 2003). The cumulative effect was the thinning of the cord.

Today, the legacy endures within hospital architecture and routine. A technocratic biomedical model, historically forged in male oriented institutions, remains dominant. In 2023, 9-in-10 births occurred in secondary or tertiary hospitals (HNZ, 2025). This model separates mind from body, hierarchies authority, and privileges surveillance and intervention - dynamics that erode confidence and suppresses whānau knowledge of normal birth (Davis-Floyd, 2001; Najafi et al., 2017). The disconnection is literally built in; labour wards resemble intensive care units, with bright lights and machinery that heighten stress and disrupt labour physiology. “Birth territory” rangahau shows how such environments disempower birthing women, rendering them passive rather than sovereign (Fahy, 2006; Lothian, 2004). By contrast, person-centered birthing rooms—dimmable lighting, concealed equipment, and space for mobility—are linked to improved outcomes (Goldkuhl et al., 2023; Nilsson et al., 2020). The environment is not incidental; it is constitutive of power.

These patterns persist. In my midwifery experience, whānau birthing in tertiary hospitals—even with no clinical risk, are often subjected to uninvited entry by Obstetricians or charge midwives during shift change. Framed as “introductions”, these intrusions undermine mana motuhake and repeat the disregard for relational and cultural protocols that marked earlier colonial interventions. As Cram et al. (2019) argue, historical ruptures have enduring impacts, shaping inequities in maternal health and alienating whānau from Māori birthing traditions. Within a Te Tiriti framework, restoring culturally grounded maternity care is not revitalisation alone but a constitutional and spiritual obligation (Jenkins & Matthews, 1998; Mikaere, 2011). Illustrating an active duty of restoration.

These dynamics are both historical and global. In early modern Europe, women healers were recast as “witches” under church and state authority (Whaley, 2011). The witch hunts of the 15th to 18th centuries dismantled women’s empirical and spiritual authority (Ehrenreich & English, 2010), while Green (2008) shows that male practitioners had entered obstetrics centuries earlier, producing medical texts that institutionalised exclusion. Bartolo (2024) adds that even midwives perceived failures were politicised to justify their removal. Read together, these accounts reveal the systematic displacement of women healers under patriarchal, medicalised regimes. The same logics travelled with colonisation to Aotearoa, where missionary conversion and biomedical expansion deliberately undermined wāhine Māori authority and dismantled Indigenous sovereignty over birth. Thus, Aotearoa’s story sits within a wider pattern of spiritual and professional dispossession.

In 19th-century Aotearoa, this took form as “moral reform.” Missionary women such as Marianne Williams targeted wāhine Māori as degraded and in need of salvation (Rountree, 2000). Through programs of hygiene, modest dress, and Christian marriage, they reframed Māori women as obedient and domesticated (Jenkins & Pihama, 2001; Rountree, 2000). Ritual, karakia, and atua were displaced by surveillance and shame (Kenney, 2011; Mikaere, 2011). The erasure of atua wāhine from education and religion fragmented the spiritual landscape: Hine-te-Iwaiwa, Hine-nui-te-pō, and Hina were replaced by Eve and Mary, embedding imported doctrines that interpreted birth through “The Fall” and diminished Mana Wāhine (Catholic Church, n.d.; Mikaere, 2011; Murphy, 2012). This theological shift re-scripted maternity itself.

Colonial schooling reinforced this severance. Māori girls were trained for domesticity and Christian morality, displacing mātauranga ūkaipō—birthing, breastfeeding, and parenting as sacred responsibilities—with ideals of service and submission (August, 2004; Jenkins & Matthews, 1998; Jenkins & Pihama, 2001). Schooling became a conduit of forgetting.

Colonial law compounded these losses. The Native Lands Acts of 1862 and 1865 dismantled collective Māori land tenure, individualising titles and alienating whenua at scale. For wāhine, this was devastating: whenua, whakapapa, and Te Whare Tangata are inextricably linked. Land loss severed security and the communal structures that protected against violence. Mikaere (2011) and Smith (2021) argue that these Acts imposed patriarchal frameworks that displaced women's authority in land and family decision-making, completing the spiritual and structural dislocation of wāhine Māori within their own cosmology. In effect, law re-mapped both land and lineage.

At the same time, new laws exposed contradictions in protection. The Cruelty to Animals Act 1878, penalised harm to animals, yet wāhine and tamariki remained unprotected. The Infant Life Protection Acts 1893 and 1896, extended state oversight into fostering and adoption but offered little safety for Māori mothers or tamariki, instead tightening Crown control over whakapapa (Reinfelds, 2025). The Child Welfare Act 1925, and Social Security Act 1938, further embedded Pākehā norms, displacing tikanga-based systems of care (Dhunna et al., 2018). In te ao Māori, violence against wāhine and tamariki was a desecration of atua, whakapapa, and whenua — carrying communal consequences such as castration, ritual ingestion of lizards, or death (Murphy, 2014). Colonial law privatised harm, hiding it within the home. For whānau Māori, this meant losing ancestral protections while gaining only surveillance without safety. Protection was promised; control delivered.

To address the realities of urbanisation, the welfare state expanded its reach through Māori welfare officers in 1938 who reported to government and later through the independent Māori Women's Welfare League (Labrum, 2004). Both were crucial conduits of Mana Wāhine in action, connecting deeply with their communities to ensure wāhine Māori had access to essentials that could shift families from survival to thrival when removed from traditional support networks (Labrum, 2004). However, these initiatives were also shaped by the broader welfare-state ideology of the time, which promoted suburban nuclear domesticity and racialized ideals of "good citizenship," thereby undermining collective living, whāngai, and extended whānau care (Nolan, 2007). The "good home" became a disciplinary tool, its logic soon extending to birthing rooms, where the private sphere once again became a site of governance.

Later reforms sought redress but could not undo this legacy. The Property (Relationships) Act 1976 granted financial independence without protection from violence. The Domestic Violence Act 1995, defined physical, sexual, psychological, and economic abuse, yet wāhine Māori remained disproportionately at risk, especially during pregnancy (Dhunna et al., 2018; Fanslow & Robinson, 2008). The Crimes (Substituted Section 59) Amendment Act 2007, and

Family Violence Act 2018, removed the defence of “reasonable force” in disciplining children, yet violence in Māori homes persisted – rooted not in culture but in colonisation, dispossession and inequity (Marsh, 2019; Wilson et al., 2021a). The same state logics that judged Māori homes against Pākehā ideals also shaped hospitals, turning them into sites of discipline and surveillance that controlled wāhine and whānau participation (Jenkins & Matthews, 1998; Kenney, 2011). These disconnections continue to shape Māori maternity care, separating wāhine from the spiritual and collective supports that once upheld birth as sacred.

Kuia interviewed by Harte (2001), remembered the sacred world of homebirth in the 1930s—communal, relational, and guided by karakia, mirimiri, and active postures. The hospital shift stripped these births of tapu and spiritual integrity. August (2004) calls this epistemic violence: the systematic invalidation of whānau, tinana, and atua in favour of institutional control. Hospital gowns replaced woven cloaks, lithotomy beds displaced crouching on the earth, neon lights replaced candle-lit wānanga. Each shift unraveled the sacred mat woven by tupuna (August, 2004; Davis-Floyd, 2001; Harte, 2001; Kenney, 2011). These are not mere aesthetic changes; they are ontological.

These ruptures continue to reverberate. Wāhine Māori remain almost three times more likely than non-Māori women to experience intimate partner violence, and over half report lifetime exposure to family violence – a disparity born of colonisation, not culture (Dhunna et al., 2018; Wilson et al., 2021a). Violence during pregnancy is especially prevalent: 13% of women report physical or sexual abuse, with wāhine Māori disproportionately affected (Fanslow & Robinson, 2008). Marsh (2019) frames this as a violation of Te Whare Tangata, compounding intergenerational trauma and disrupting māmā-pēpi bonding. In this way, colonial legal failures echo through whakapapa, making trauma both historical and lived.

Institutional policy continues to shape maternity care. Kaupapa Māori antenatal rangahau shows residual COVID-era controls narrowed whānau presence and reduced staffing—with some services limiting support to one partner and others facing enduring midwifery shortages (Below, 2024). Many services exclude partners and children from appointments, restricting cultural and spiritual support at critical moments (Below, 2024). In Tairāwhiti, only one overnight support person is permitted (Hauora Tairāwhiti, 2021). Yet Right 8 of the Health and Disability Services Consumers’ Rights state every consumer may have chosen support persons present unless safety is compromised (Health & Disability Commissioner, 2023). Such “safety” restrictions reveal how institutional control displaces whānau authority in maternity care-rights without resources are brittle.

Postnatal care in Aotearoa follows remuneration frameworks that reflect biomedical definitions of success rather than holistic recovery. Recent national cost analyses show that funding is largely concentrated around the birth event, with most resources directed to measurable procedures and short-term hospital admissions rather than ongoing postnatal wellbeing (Anderson et al., 2024). Funding models quantify visits, procedures, and in-patient stay length, portraying maternal healing and the infant's transition to whānau life as outputs rather than relational or spiritual processes. Despite midwifery's holistic philosophy, these economic structures render the wairua, social and cultural dimensions of recovery invisible in both data and policy (Kolo, 2024; NZCOM, 2015). Postnatal rituals common in other cultures remain largely absent in New Zealand's maternity system, reflecting a position that privileges efficiency and cost over connection and continuity.

The current government's proposed three-day postnatal stay has been celebrated as progress (New Zealand Parliament, 2024b), yet it merely formalises an entitlement long provided under the Primary Maternity Services Notice 2007 and reaffirmed in 2023 (Ministry of Health, 2007, 2023a). While the update revised payment structures, it did not expand service duration or address chronic workforce shortages, facilities, or home-help essentials for genuine recovery. Postnatal wards are short-staffed, midwives overstretched, and beds limited—leaving wāhine in shared rooms with little privacy or rest (Curran, 2025). Many mothers discharge early to escape exhaustion, only to return home to childcare and domestic duties before body or spirit have healed (Finlayson et al., 2020; Sacks et al., 2022).

Beyond midwifery visits, no national framework or culturally grounded model supports maternal healing. Hapū Ora rangahau shows that true postpartum wellbeing depends on whānau connection, cultural grounding, and time for restoration (Edmonds et al., 2022). Without these, a "three-day stay" becomes symbolic—a policy measured in hours, not healing. Time alone does not equal restoration.

These gaps reveal how far birth has drifted from the sanctity of home. Traditionally, within the whare kōhanga, wāhine and pēpi remained together until balance was restored: pathways between cosmos and earth were ritually closed, whenua and iho returned to Papatūānuku, and spiritual cleansing performed before wider whānau contact resumed (Best, 1975; Kenney, 2011; Papakura, 1938; Rameka et al., 2023). During this sacred period, kai was prepared by whānau and left midway between the village and the whare kōhanga, where attendants collected it—ensuring nourishment while maintaining tapu (Best, 1975, p. 14). The mother's only responsibilities were to rest, eat, and heal, supported by collective whānau vigilance. The logic was simple: protect the dyad so whakapapa could balance.

Contemporary rangahau affirms that these principles endure. Clapham's (2023) HOPE study found homebirth environments allowing mothers to rest and feed without interruption created a peaceful continuum of recovery, where wāhine and pēpi "thrived instinctively when allowed to take the lead on initiating feeding and resting." Similar practices across Indigenous cultures—ritual seclusion, prayer, and specialised diets—safeguard the dyad and prepare them for reintegration (Backes et al., 2022; Yesildag et al., 2024). By contrast, western norms expect women to resume duties within days, eroding structured healing and communal care (Eberhard-Gran et al., 2010). The absence of a defined postnatal protection period in Aotearoa reflects neglect, tikanga remains invisible in policy despite its centrality to wellbeing and wairua.

This disconnection extends into infant feeding. Regional breastfeeding policies, shape whether whānau may enact whāngai ū. Breastmilk is inherited rongoā, cloaking pēpi in whakapapa and lifelong health (Tupara, et al., 2023), yet it is inconsistently valued. In Canterbury, whāngai ū sits at the bottom of the "infant feeding hierarchy" and is discouraged through risk disclaimers (Te Whatu Ora, 2024f; HNZ, 2024a, 2024b). By contrast, Lakes District Health Board (2020b) recognises whāngai ū as cultural practice, offering balanced information and upholding choice. Yet all facilities must meet Baby Friendly Hospital Initiative [BFHI] accreditation, exposing inconsistency. Such uneven practice undermines Consumer rights (HDC, 2023), and makes equity postcode dependent.

National frameworks mirror this silence. The New Zealand Breastfeeding Alliance [NZBA] (2024) recognises Te Tiriti and claims to uphold Māori aspirations yet omits explicit reference to whāngai ū - in a continuation of their national breastfeeding policy. Instead, donor milk is biomedicalised—classified, pasteurised, and regulated—while tikanga-based reciprocity is ignored (HNZ 2024a, 2024b; NZBA, 2024). This framing reinforces formula feeding as the norm: by treating milk as a product rather than a living whakapapa substance, policy drifts toward what the Baby Friendly Initiative terms as "bottle-feeding culture," where artificial feeding is perceived as standard and breastfeeding becomes the exception (NZBA, 2018). Such silence risks portraying Māori practices as unsafe or unclean, echoing colonial narratives that framed menstruation and the Māori maternal body as polluted and in need of regulation (Mikaere, 2011; Murphy, 2012; Jenkins & Pihama, 2001). The result is a postcode lottery that breaches Te Tiriti and undermining mana motuhake in choosing the best pathway for pēpi (Below, 2024). Equity cannot depend on geography.

These inequities are not only clinical but epistemic. The suppressive logics of the Tohunga Suppression Act 1907 live on in midwifery governance. Rongoā Māori remains framed as "complementary or alternative medicine" (Mark, 2012; Waitangi Tribunal, 2011), a position

reiterated by NZCOM (2018). Though presented as progressive, this framing reflects feminist health movements seeking biomedical legitimacy rather than centering Mana Wāhine. Māori scholars emphasise rongoā as a constitutionally guaranteed taonga and worldview (Mark, et al., 2019). Classifying it otherwise reinscribes colonial hierarchies of knowledge, echoing 1907 suppressions. Naming defines status, status shapes practice.

This tension extends to the Midwifery Council's revised Scope of Practice (2024b), which embeds Te Tiriti and requires valuing mātauranga Māori alongside clinical expertise. Yet the wider health system still constrains Kaupapa Māori maternity services. Its apparent embrace of Indigenous knowledge remains shaped by institutional logics that historically excluded wairua from childbirth education and service design. Reviews show Indigenous peoples remain largely absent from program design and evaluation, with little Aotearoa-based evidence (Barrett et al., 2022). This absence breaches Te Tiriti and the right to spiritually informed parenting. Systemic disruptions persist: some wāhine conceal needs for fear of judgement, others receive no postnatal follow-up despite referral, fraying wairua when aroha, awhi, rongoā, and tautoko are most needed (Barrett et al., 2025; Stevenson et al., 2016). Inclusion must be infrastructural, not symbolic.

At its core, this is not policy failure but spiritual rupture. Love (2004) reminds us that wairua is not an add on but the first dimension of wellbeing, the essence of all relationships. When maternity systems exclude it, they sever the foundation of whānau ora. Although many whānau retain spiritual frameworks, colonisation and language theft have diminished the environments that nurture them, leaving practices often unspoken or private (Love, 2004). Even so, quiet work continues—whispered oriori, memory held karakia, small acts of ceremony sustained in isolation. With collective readiness, these threads can be rewoven through Kaupapa Māori midwifery, wānanga, and whānau presence. The cord is frayed, not broken.

The spiritual responsibility within Te Whare Tangata is core to Mana Wāhine theory, recognising it as a site of mana motuhake—authority, autonomy, and intergenerational continuity. The medicalisation of birth and criminalisation of Māori midwifery severed the transmission of wairua and disrupted whakapapa (Keelan-Peebles, 2022; Le Grice, 2014). Such disconnection imprints spiritually, culturally and biologically, carried in body and blood across generations (Marsden, 2003; Mikaere, 2011). Disruption becomes inheritance.

Contemporary science echoes this through epigenetics, showing how environment, stress, and ceremony leave molecular marks that can be inherited (Feinberg, 2018; Nilsson et al., 2018). By the fifth month of gestation, a female fetus already carries the oocytes of future

mokopuna (Huber & Fieder, 2018). Stress-related disruptions such as NR3C1 dysregulation, reduce immune resilience and may persist intergenerationally (Shields et al., 2021). Conversely, spiritually anchored environments—ritual with sacred intentions, like karakia, are associated with beneficial epigenetic patterns and immune balance (Silva Caldeira, 2023). In Kaupapa Māori terms, wairua-safe care is biochemical protection, some epigenetic effects even escape germline reprogramming, extending across generations (Migicovsky & Kovalchuk, 2011). Here, mātauranga Māori and science converge: the intergenerational impact of wairua is mirrored at the molecular level.

The Waitangi Tribunal's Mana Wāhine Inquiry (WAI 2700) identifies this disconnection of wairua and birthing sovereignty as systemic and intentional, evidencing entrenched Crown denial of Mana Wāhine (Waitangi Tribunal, n.d.). The Takapou Whāriki report confirms centuries of institutional erasure with enduring consequences (Potter & Simmonds, 2024). Severing Te Whare Tangata breaches whakapapa spiritually, epigenetically, and constitutionally (Gabel, 2019; Yates-Smith, 2003). Colonial disconnection is therefore not only rupture or imprint, but constitutional breach- demanding redress and restoration.

These patterns are not unique to Aotearoa. Across colonised societies, women entrusted with reproductive knowledge were targeted—not for harm, but for their authority. In Scotland, folk healers and midwives accused of witchcraft were criminalised as male medical power rose (Ring et al., 2024). In Hawai'i, a 2018 licensing law effectively outlawed customary apprenticeship midwifery, later halted after cultural and constitutional challenges (Davis, 2024; Hawaii State Legislature, 2018; Native Hawaiian Legal Corporation, 2024). Whether labelled witches, pāhūpū, or tohunga, these were custodians of sacred ceremony. To criminalise them was to criminalise wairuatanga- the names change, but the logic remains. The global pattern is clear: it was never birthing knowledge itself that was feared, but the authority it represented, the same authority colonial policy sought to extinguish in Aotearoa.

The role of the midwife as guardian and weaver of ritual can also be understood through morphic resonance. Sheldrake (2006) suggests that established patterns leave imprints recurring across time and space. Though articulated in western metaphysics, this aligns with Māori understandings of whakapapa and tikanga as ancestral templates imprinted through generations. Heke (2023) explains that enacting tikanga in birth is not a rote performance but resonance with sacred templates laid down by tupuna, while Dell's (2021) rongomātau—"sensing the knowing"— shows how ancestral knowledge is activated without speech. Midwives thus act as tuning forks, aligning with these fields and reawakening ancestral expression in contemporary births (Dell, 2021; Sheldrake, 2006). Te Whare Tangata is both

physical and spiritual portal where ancestral birthing knowledge is remembered and made present (Heke, 2023; Marsden, 2003). In practice, resonance becomes ritual.

When wairuatanga is excluded from maternity services, these promises are dishonoured. Its absence is not merely cultural omission, but a constitutional breach (Mikaere, 2011; Rae et al., 2022). Despite this, Māori continue to birth well—but endurance is not equity; it is resilience in the face of erasure (Kenney, 2011; Dawson et al., 2019). Naming the body in te reo—tōnetōne, werewere, tara, waha kōpū, Te Whare Tangata, pūkākano—is both political and spiritual resistance. Each oriori sung, each iho tied with muka, whenua buried, and each pēpi breastfed is a whiri rewoven into the whāriki - a stitch of reclamation.

Birth is a sensitive window of imprinting: maternal stress, trauma, hormones, and obstetric intervention can alter DNA methylation and immune development across generations (Ragusa et al., 2019; Nilsson et al., 2018; Migicovsky & Kovalchuk, 2011). Unconsented synthetic oxytocin, anaesthesia, or forced immobility risk inscribing trauma (Buckley, 2015; Dixon, 2013). By contrast, continuity of care, undisturbed skin-to-skin, breastfeeding, and spiritual presence support healthy neuroendocrine imprinting (Moore et al., 2016; Widström et al., 2019), validating what Māori already know of wairua-led birthing (Kenney, 2011; Mikaere, 2011). Vaginal birth and breastfeeding also pass ancestral microbiome to pēpi (Dominguez-Bello et al., 2010; Rodríguez et al., 2015). The body remembers, so does whakapapa. Memory is cellular and sacred.

Even within medicalised environments, threads are being rewoven. Māori midwives carry ancestral wisdom into rooms not designed for it, making space for wairua to breathe. Their work is simultaneously clinical, cultural, and constitutional healing (Kenney, 2011; Potter & Simmonds, 2024; NZCOM, 2022; Te Whatu Ora, 2023). Institutional signals—such as the 2019 tender for a Māori Midwifery degree—show a movement toward culturally grounded education (Te Whare Wānanga o Awanuiārangi, 2019). Reports such as Taku Waipiataata, Taku Hei Tāwhiri claim tamariki as sacred atua in human form, imbued with mana, tapu, and mauri (Angeli Gordon, 2025; Pere, 1991; Mikaere, 2011). Pregnancy and birth are sacred rites of passage requiring spiritual accompaniment (Yates-Smith, 2003). Midwives who center wairuatanga—through karakia, intuitive touch, and pūrākau—act as kaitiaki upholding the sanctity of Te Whare Tangata (Kenney, 2011). This is reclamation in practice.

Exploring the absence of wairua-led care shows how wāhine Māori as Te Whare Tangata carry the long-term consequences of spiritually disconnected maternity care on personal, whānau, and intergenerational levels. This analysis responds directly to rangahau questions two and three. Tracing the topenga of these cords is both political and spiritual, calling not for

acknowledgement but transformation. Each birthing ritual reclaimed becomes a whiri of resistance and renewal, rewoven into the whāriki for those yet to come. The remedy is relational and ritual.

The pōwhiri process now carries us from the charged winds of the ātea into whakanoa and whakawhanaungatanga. The weight of institutional rupture gives way to relational practice, where the midwife's karanga and lived journey re-enter the kōrero. Tapu begins to ease, and the wairua of care is restored through intimate, embodied connection, where the cord remembers.

2.5 Te Wakahuia o Hine | Tōku ara whakapapa, tōku ara wairua: The sacred vessel of Hine – restoring the Midwife's spiritual integrity.

"*I did not choose this path. The karanga came from deep within, from Hine-te-Iwaiwa, from my own blood memory. I simply answered. Through whakapapa, I was guided to a celestial path that called my wairua to rise and meet the sacred doorway of Te Whare Tangata. This doorway, this tara, is not just anatomical; it is also a portal of power where life and knowledge converge. The call to midwifery was never only professional. It was cosmological*."

This section enters the whakanoa space – the easing after the ātea, where whakawhanaungatanga begins. Here the spiritual pepeha and whakapapa of the midwife flow into the kōrero, interweaving guardianship, personal growth, ancestral obligations, and professional practice. To uplift the sacredness of Te Whare Tangata, the midwife must also tend the sacredness of her own wairua. Without that inner grounding, karakia, intuition, and tikanga cannot be carried with integrity into practice. International research echoes this: awareness of one's own spirituality and reflective practice are prerequisites for providing effective spiritual care (Attard et al., 2020). The midwife's wairua is not beside her role; it is the embodied guide that safeguards Te Whare Tangata.

For many Māori midwives, the journey begins not with rational choice but with hearing a karanga — a call from atua and the pulse of whakapapa. More than ritual, karanga is a cosmological act linking us to creation and ancestral knowledge (Hibbs, 2006). Aligned with Hine-te-Iwaiwa (Toki et al., 2022), it acknowledges not only people but atua, tupuna, kaitiaki, manu, ngāhere, awa, and whenua, weaving spiritual and ecological relationships (Toki et al., 2022). The karanga into midwifery is both vocation and initiation, calling practitioners to mediate between realms, connect generations and restore balance. Hayes (2011) describes this as remembering the goddess — listening to dreams, intuition and unconscious stirrings as sacred instructions. For Māori midwives, such instincts are ancestral legacies of healing. As kaitiaki of Te Whare Tangata, the midwife's inner life is foundation, not surplus. Answering

the karanga carries obligations: to look inward and outward, to practice reflection as our tupuna did.

The profession now requires reflection through the Midwifery Standards Review (Midwifery Council of New Zealand, 2024b), yet reflection long predates regulation. Across traditions it is the bedrock of professional identity – a whole-person discipline integrating mind, body, and spirit (Bass et al., 2022). Māori midwives inherit a lineage of Indigenous science: ancestral observation, questioning, and alignment with atua and whenua. Elendu (2024) situates this within a 3,000-year continuum of holistic healing where imbalance was discerned through body, dreams, omens and spiritual insight.

As reflected earlier in my experiences of wairua sensitivity, a moemoeā once revealed the timing and complications of a whānau birth weeks before they occurred. Though distant and without clinical knowledge, the dream gave details later confirmed when pēpi was born prematurely. For me, this reaffirmed te ao wairua — that whānau remain connected across realms and that dreams act as diagnostic pathways through which wairua communicates imbalance and urgency.

Durie's (1998) Te Whare Tapa Whā model carries this truth forward, emphasising taha wairua as equal to taha tinana, taha hinengaro, and taha whānau. Here, professional and ancestral reflection meet — both essential if Te Whare Tangata is to be upheld. International scholarships echo this insight, Zahran (2019) describes such instincts as a 'sixth sense'. Sanusi et al. (2021) show that spiritual and psychological states shape nausea severity in pregnancy, while Davis (2003) locates this within Indigenous consciousness, where the body expresses imbalance as an invitation to restore connection with soul, community, and environment.

Dell (2021) names this ancestral intuition as Rongomātau — a way of receiving tohu that guides Māori knowing. I experienced this when a whānaunga sought help for a hapū māmā overwhelmed by nausea. Without clinical context, my instinct turned to wairua: was there uncertainty about the hapūtanga? Was pēpi being resisted spiritually, preventing deep implantation? Such questions move care from symptom management to restoring harmony between māmā, pēpi, wairua, and whānau. When my kōrero was shared, the māmā confirmed the resonance. This is midwifery's spirit-work; not beyond the clinical, but beneath it — safeguarding the womb's tapu by tending to the midwife's inner sight.

When Māori midwives engage this way, they draw on tupuna gifts — reading beyond the symptom into wairua patterns and recognising healing as relational, historical, and future-facing. This way of knowing is not an alternative to midwifery; it is its essence.

My own journey as a māmā revealed this most vividly. During motherhood I entered the shadows of postpartum depression, where my wairua confronted me most starkly. The moon became my companion, guiding me toward Hine-te-Iwaiwa. Under her light, I reframed pain as initiation, an embodied journey calling me into deeper reflection and healing. This was shadow work that transformed my understanding of self as wāhine, māmā, and midwife.

Semmons (2006), found that wāhine Māori experiencing psychological distress during hapūtanga and childbirth often interpret their journeys through spiritual frameworks, locating meaning in whakapapa, wairua and atua rather than in pathology alone. Champ (2017) interprets postpartum depression as relational and cultural transformation. Cannon (2024) frames it as archetypal initiation where death and renewal interweave through dream and ritual. Roulleau (2023) shows how archetypal healing enables embodiment of divine feminine energies as tools of restoration. For me, the moonlit presence of Hine-te-Iwaiwa became both mirror and guide — urging me to grow so I might walk alongside other wāhine and pēpi in their transitions from shadow into light. The bridge is clear: formed midwife spirituality makes possible spiritually safe protection of Te Whare Tangata.

Within institutions, this inner work is tested by outer conditions. Professional tensions, symbolic violence, and institutional backlash remain common for wāhine Māori in midwifery. These are not “tests” to endure but expressions of colonial and patriarchal structures that erode wairua. Excessive stress, hostility and lack of support diminish practitioners’ spiritual care and presence (Hu et al., 2025). To move through these requires clarity - to name behaviours directed toward us, refuse mana-munching and stand firm in integrity. Sometimes that means standing alone to protect one’s own wairua and the kaupapa. Phoenix (2019) uses Goddess Inanna’s descent as metaphor—confronting shadow, integrating pain without martyrdom, and returning wiser.

These individual trials are mirrored collectively. Across Aotearoa, the very sectors defined by care — midwifery, nursing, teaching, social work, and first response — are struggling beneath unsustainable strain. On 23 October 2025, more than 100,000 public-sector workers joined a national mega strike for safer staffing, fair pay and recognition of the emotional and relational labour sustaining wellbeing (One News, 2025; New Zealand Herald, 2025). Their action arose from the same fracture midwives know intimately: systems demanding endless giving while undervaluing the spiritual and relational work that holds communities together. This crisis

deepened when the government halted multiple pay-equity claims across health and education, including midwives and nurses — a move union condemned as “a blatant and shameful attack on women” (Kaitiaki, 2025; NZCOM, 2025). A Radio New Zealand [RNZ] report confirmed that dozens of existing claims were discarded and new thresholds imposed, “raising the bar” for women in female-dominated workforces (RNZ, 2025).

The Government’s Kia Toipoto Public Service Action Plan 2021-24, acknowledges that inequities stem from structural bias and the undervaluation of care-based work, calling for Te Tiriti-grounded partnership and values of manaakitanga and whanaungatanga to restore balance (Te Kawa Mataaho Public Service Commission [TKMPSC], 2021). Its companion plan, Māori, Pacific and Ethnic Pay Gaps Work Plan 2023, centers wāhine Māori, Pacific and ethnic women, urging authentic partnership, leadership development and culturally grounded accountability (TKMPSC, 2023). For midwives, these movements illuminate that spiritual integrity cannot be separated from material equity. When the work of care is undervalued, wairua suffers; collective pursuit of justice begins the restoration of mauri.

In Aotearoa, leadership visibility is policed through the Tall Poppy Syndrome [TPS], disciplining wāhine leaders to downplay achievement and perform modesty (Holmes, et al., 2017). The trials Māori midwives face — isolation, opposition, burnout — are part of wider “social descents” that demand resilience yet must never be normalised. Hagerty (2025) reminds us that healing requires descent into pain and reconnection with the divine feminine as source. For midwives, reflective practice is therefore not only professional growth but soul-making — attunement to atua wāhine in service of the womb.

Such experiences are also generational. Each generation is asked to heal a portion of the wound, described in Indigenous healing literature as intergenerational or transgenerational healing (Brave Heart, 1998; Saunders, 2014) and in-depth psychology as shadow work for collective growth (Jung, 1968). Transpersonal psychology adds that healing integrates ‘shadow’ and ‘self’, releasing blockages through spiritual acceptance (Raković, 2021). These are not abstractions but competencies of care that keep Te Whare Tangata spiritually intact.

Yet healing cannot be confined to psychological explanations. Persistent inequities in health systems are not technical failings but symptoms of patriarchal wounding —structural violence that severs wahine, whenua, and wairua from their sacred interdependence (Came et al., 2021; Murdoch, 2023). Within this wound, colonisation and biomedical dominance have obscured the divine and ecological dimensions of care that once flourished under Māori maternal cosmologies. Nicolae (2022) describes the revival of goddess spirituality as political resistance, reclaiming menstruation, fertility, and sexuality as sacred sources of creation rather

than shame. This reclamation is mirrored in Māori contexts, where the revitalisation of atua wāhine knowledge reconnects birth, blood, and body to whakapapa — the genealogical continuum binding people, land, and atua (Murphy, 2016; Simmonds & Gabel, 2016).

Māori midwifery moves within a wider circumpolar current of spiritual resurgence — a turning tide of remembering flowing through the waters of Hine-te-Iwaiwa (Heke, 2021; Tupara & Tahere, 2020). Within these currents, Māori midwifery becomes the living ceremony of Hine-te-Iwaiwa herself, re-embodied through the resurgence of ikura rites, hapū wānanga, and Mana Wāhine praxis that restore menstruation, conception and childbirth as sacred transitions rather than medical events (Barrett et al., 2022; Murphy, 2019; Simmonds & Gabel, 2016; Poutama Rites of Passage, n.d.). Through karakia, rongoā, whanaungatanga, and manaakitanga, Māori midwives affirm whānau mana — standing as kaitiaki who safeguard tapu and nurture the spiritual ecology of care (Simmonds & Gabel, 2016; Heke, 2024). Iseke-Barnes (2003) reminds us that Indigenous peoples working within institutions endure through embodied spiritual resistance — revitalising ceremony and refusing to sever knowledge from self. When the midwife is spiritually grounded, the womb is safe.

Healing also unfolds collectively. Hayes (2011) frames women's dream circles as therapeutic containers where all voices are equal, intuition is nurtured and authority rests with the dreamer. This mirrors Māori hui, birthing rituals, and collective wānanga, where midwives and whānau co-create healing spaces. Similarly, sweat lodges (Kailo, 1998) and moon ceremonies (Iseke-Barnes, 2003) act as womb-like vessels of rebirth, strengthening the midwife's capacity to hold Te Whare Tangata in sacredness.

Reclaiming Māori midwifery is therefore more than professional development – it is remembering wholeness and restoring what colonisation severed. Hayes (2011) calls this healing from "injured instincts". Murdoch (2023) names it "returning to the wild" and Davis (2003) frames it as "reunion with the Great Mother." The midwife's spiritual path is the womb's protection. When Māori midwives honour wairua — asking deeper questions, reading tohu, seeing beyond symptoms — they embody professional excellence and ancestral sovereignty, lifting the sanctity of Te Whare Tangata.

Many Māori midwives walk with dual identities — raised away from te ao Māori yet spiritually drawn toward birthing work that reconnects them with whakapapa. While mainstream midwifery education offers clinical skills, it often lacks cultural mentorship and relational grounding (Davies et al., 2022; Pihema et al., 2023). This gap depletes graduates before they even enter the workforce (Davies et al., 2022; Simmonds et al., 2025). Still, birth itself awakens dimensions of wairua, mauri, and intuition that textbooks cannot teach.

These awakenings mirrored my own journey, revealing what Linhares (2012) calls the “sixth sense” — a spiritually infused intuition many midwives recognise as part of their calling. This guidance, or “mana from heaven”, is not taught in textbooks, but felt through the puku, breath, and wairua. Mentors refined my practice, yet my tamariki and whānau awakened the healer within. Upholding tikanga in practice is not optional — it is cultural perseverance (Midwifery Council of New Zealand, 2024a). Māori midwives carry both clinical responsibility and the intergenerational task of protecting and embodying mātauranga (Keelan-Peebles, 2022; Tassell-Matamua et al., 2023; Tupara & Tahere, 2020).

This task encompasses the values at the heart of midwifery tikanga: karakia to call in guardianship, mirimiri to restore mauri, whanaungatanga, wai and rongoā to cleanse and settle, whenua-ki-te-whenua rituals, and safeguarding tapu through language, placement, and spiritual preparation (Berryman et al., 2022; Keelan-Peebles, 2022; Tassell-Matamua et al., 2023). These align with the Midwifery Council’s (2024a) Scope of Practice, informing midwifery is both cultural and clinically –grounded in mātauranga Māori and the protection of Te Whare Tangata. Supporting one another is not only kindness but professional duty (Calvert, 2011; Midwifery Council of New Zealand, 2024a). Kindness and awareness ensure no midwife carries an unsustainable load (Thapar-Björkert et al., 2016). The sustainability of the workforce is essential to public health (Bourque Bearskin et al., 2024). A spiritually safe workforce is, ultimately, a spiritually safe womb.

To address systemic gaps, a collective of Māori midwives and students in Tāmaki Makaurau re-centered mātauranga Māori through wānanga-based learning, restoring the spiritual dimensions of care sidelined in mainstream midwifery. Through relational leadership, they built strong ties with hauora Māori services, iwi providers, and tertiary institutions, creating an intergenerational space for cultural reclamation and education (Te Wakahuia o Hine, n.d.). Yet visibility also brought resistance - a familiar pattern in Indigenous health spaces (Johnston, 2005). The tensions revealed the limits of inclusion and how symbolic violence can surface within Māori-led initiatives when mana and influence are perceived as threat (Johnston, 2005; Thapar-Björkert et al., 2016).

Bourque Bearskin et al. (2024) records that these experiences are global: Indigenous health professionals are often tokenised, burdened with cultural labour and denied the spiritual safety needed to thrive. Across contexts, institutions reproduce racism and symbolic violence through expectations that Indigenous practitioners will give more, tolerate more, and conform more—all while carrying their communities spiritual and relational obligations (Came, 2012; Elias & Paradies, 2021; Gerhard et al., 2022). These dynamics confirm that what unfolds in

Māori midwifery is not personal inadequacy, but structural violence disguised as professionalism.

My experience of symbolic violence—within both colonial and Māori-led structures—is not isolated. Johnston (2005) outlines how wāhine Māori face dual marginalisation: first by the Crown and again by hierarchical Māori systems. This is not merely interpersonal but constitutional. She argues that iwi, hapū, and professional bodies can reproduce the very exclusions they seek to dismantle, and that wāhine Māori hold both the right and responsibility to reshape tikanga and professional spaces when these become sites of silence or harm. As Calvert (2011) and McIver (2002) note, horizontal violence fractures relationships, erodes self-worth and compromises the wairua of care.

Bourdieu (1973) termed this symbolic violence — an invisible domination accepted as normal. In midwifery, it appears through exclusion, gatekeeping, and hierarchies of mana. Thapar-Björkert et al. (2016) show how misrecognition and power imbalances persist even in spaces claiming inclusivity. Wilson et al. (2021b) confirm that Māori continue to encounter culturally unsafe, alienating environments where the absence of whakawhanaungatanga, wairua, and whānau-centered care reproduces colonial harm. When aroha, manaakitanga, and humility are overshadowed by ego and hierarchy, the colonial dynamics re-emerge under Māori names (Johnston, 2005; Thapar-Björkert et al., 2016).

Holistic midwifery demands more than cultural performance; it requires spiritual alignment, collective care, personal growth and wairua integrity (Keelan-Peebles, 2022; Tassell-Matamua et al., 2023). Moko kauae, worn by many wāhine Māori, embodies whakapapa, leadership, and spiritual accountability (Te Maihāroa, 2023). It is not aesthetic but covenant - kanohi ora, the living face of tupuna — a symbol of Māori resistance, mana motuhake, and maternal strength. For wāhine Māori in midwifery, it is both taonga and responsibility: to protect Te Whare Tangata through competence, humility and inherited strength.

From these tensions arose Te Wakahuia o Hine — anchored in fresh whakapapa and guided by a formal trust deed. Emerging from Ngā Māia ki Tāmaki Mākaurau, it reaffirmed wairuatanga and collective healing as foundations of Māori midwifery. This was not departure but realignment: a return to spiritual values prioritising cultural integrity and collective wellbeing. We sought to create safe spaces online where mātauranga could flourish without political interference or institutional compromise. Rapuā te Aronga-a-Hine asserts that Māori midwifery must uphold the sacredness of Te Whare Tangata through wairuatanga, tino rangatiratanga and intergenerational transmission of mātauranga (Tupara & Tahere, 2020). Our right to practice within a spiritually congruent framework is not aspirational but

constitutional, grounded in Te Tiriti and the mana of Hine-te-Iwaiwa. The formation of Te Wakahuia o Hine was one such response —seeking not only safety but sovereignty of te wairuatanga o te wāhine.

The midwife's personal and professional growth cannot be separated from the cultural and institutional contexts in which she practices. Halldorsdottir and Karlsdottir (2011) emphasise that the "good midwife" is defined not only by competence but by wisdom, caring and relational integrity. In Aotearoa, Holmes et al. (2017) illustrates how TPS further compounds these dynamics, with fractures of recognition mirrored within midwifery itself. For Māori midwives, TPS intersects with Kaupapa Māori obligations and institutional frameworks, creating unique vulnerabilities. Speaking out or leading initiatives can invite symbolic violence framed as cultural policing. In such environments, self-development becomes not vanity but resistance-kaitiakitanga protecting the tapu of Te Whare Tangata and the wairua of care.

To be Māori, a midwife, a whānau member and a visionary within an under-resourced system is a relentless burden. Workplace violence and management complicity drive burnout and attrition (Capper et al., 2022). Community midwifery remains sacred yet unsustainable: practitioners are expected to be constantly available, uphold cultural safety, educate and run a business within a funding model that undervalues every facet of this work (Capper et al., 2022; Moran et al., 2023; Sidhu et al., 2020). Newly qualified Lead Maternity Carers are leaving practice as remuneration fails to cover costs, many burning out under the weight of delivering an internationally recognised program of best practice that remains structurally unsupported in Aotearoa (Brettkelly, 2025).

The Equal Pay Amendment Act 2025 compounds these inequities. By discontinuing thirty-three claims and tightening eligibility, it raises new barriers to fairness (Breen, 2025; McGregor, 2025). For midwives under MERAS agreements, pay and conditions remain stagnant, while burnout persists (Eddy, 2025; RNZ, 2025). The Public Health Association (2025) warns that the reforms exclude much female-dominated, relational, and culturally grounded work, leaving wāhine Māori—who face a 21% pay gap—most precarious. When midwifery is materially depleted, spiritual care is the first silenced. Moloney and Gair (2015) advise that empathy and spiritual presence are ethical obligations: when midwives are spiritually grounded, birth becomes empowerment; when absent, wairua is severed.

These findings echo the mamae I have witnessed and felt, in spaces where spiritual safety is overlooked. Pezaro et al. (2016) show how distress among midwives affects both workforce and birthing people: mothers recall seeing midwives cry, withdraw, or break down—tohu that burnout was unprocessed. When the wairua of the midwife is unsupported, the tapu of Te

Whare Tangata is compromised. Midwifery cannot survive in isolation; it must be nourished through collective, systemic care.

Stevenson et al. (2020) Te hā o whānau framework offers one pathway: a culturally responsive model grounded in manaakitanga, wairua, and tino rangatiratanga. While centered on whānau wellbeing, it highlights the transformation needed for Māori midwives to restore spiritually safe, tikanga-aligned care. Pihema et al. (2023) extends this through Māori-led mentorship—reciprocal, spiritually grounded relationships based on whakapapa, wānanga and whanaungatanga. Such mentorship is both political and relational, restoring mana and sustaining Māori midwives under emotional and spiritual strain. These models align with the kaupapa of Te Wakahuia o Hine, confirming that Māori midwifery will flourish only when its environment is remade, not merely replenished.

The experiences of Māori medical trainees in obstetrics and gynaecology mirror this mamae. Simmonds et al. (2025) found that Māori registrars often carry the invisible weight of cultural loading — expected to represent, explain and justify their identity in systems that rarely protect it. Many described spiritual depletion, professional isolation and disconnection from tikanga. One trainee on leave for burnout, reflected: *"I realised I shouldn't medicate for a systems issue — it's not a personal problem at the core of it" – p. 29*. Such kōrero makes clear that Māori clinicians are not failing the system; the system is failing them (Simmonds et al., 2025). This depletion begins early: Davies et al. (2022) found third-year midwifery students already emotionally and spiritually exhausted before graduation, fearful of losing balance and wairua within unsafe professional cultures.

Research shows that self-enhancement values, such as power and achievement, embedded within hierarchical biomedical systems, prioritise control and efficiency but erode relational and spiritual care (Ardenghi et al., 2021; Du et al., 2022). By contrast, self-transcendence values such as benevolence and universalism—central to kaupapa Māori midwifery, foster whanaungatanga, manaakitanga and wairua-led reflection that protects Te Whare Tangata (Leijen & van Herk, 2021). Yet biomedical dominance persists, producing inequities that harm both Māori patients and practitioners, who carry disproportionate cultural load within unsafe systems (Reid, 2013; Stevenson, 2018).

These findings echo the kaupapa of Te Wakahuia o Hine: Māori midwives carry the weight of an entire system. Spiritual safety, mentorship and collective uplift are essential to thrive. When mindfulness is rooted in mātauranga Māori, it becomes tikanga - a vessel for recovery, reflection, and reconnection. Pezaro et al. (2016) shows that unresolved trauma, bullying, and compassion fatigue, threaten both midwives' wellbeing and patient safety. Caring for midwives

is therefore not optional but an ethical imperative. A psychologically safe midwifery workforce is essential for spiritually safe care. I have participated in compulsory training where non-Māori colleagues have suggested that Māori workforce density negates inequity—an unrealistic expectation that Indigenous practitioners can “fix” one-hundred-eighty-five years of colonial harm in their practice. Similar dynamics are evident across other professions, where Indigenous staff are burdened with enacting institutional change while structural racism remains unaddressed, a paradox of diversity that compounds trauma and burnout (Thomas & Nolan, 2024).

Tassell-Matamua et al. (2023) explains that wairua is central to Māori wellbeing and resilience, with practices such as karakia and mōteatea protecting against depletion. Their insights reinforce what Māori midwives already know: spiritual care sustains both whānau and practitioners. Moran et al. (2023) likewise found that midwives facing burnout, trauma, and moral injury within unsafe medicalised cultures - yet autonomy, continuity models and non-hierarchical support were protective, confirming that when midwives practice in alignment with their values, mauri is restored.

True resilience is collective, fostered through culture, funding and environments that protect spiritual safety. Without wairua, connection and systemic support, midwifery becomes unsustainable — a disconnection visible in rangahau and felt in practice. Sidhu et al. (2020) confirms that burnout is not weakness but systemic failure, driven by excessive workload, poor renumeration, toxic culture and lack of autonomy, while continuity of care protects midwives through trust and relationship.

Doherty and O’Brien (2022) describe burnout as extinguishing the inner flame — the force animating caring professions like midwifery. They reveal how “unit burnout,” marked by toxic culture, scapegoating and incivility, corrode collective connection. Hastie (1995) likewise observed how “midwives eat their young”, eroding confidence, depleting wairua and undermining care. Healing, these studies suggest, arises not from policy but from relational safety. Informal peer wānanga—spaces for debrief and reflection, restore what institutions cannot. Burnout is not personal failure but cultural, relational, and spiritual fracture (Doherty and O’Brien, 2022).

Holistic practice is not ritual performance but embodiment of whakapapa, wairua, and pono. Spirituality deepens presence, empathy and trust, enriching birth for both māmā and midwife (Kızılca Çakaloz et al., 2023). Conversely, burnout and trauma erode compassion (Akın et al., 2021). System design either constrains or enables spiritual presence. In Queensland maternity wards, a postnatal ratio of 1:6 improved culture, reduced neonatal admissions, and

shortened stays (Queensland Health, 2024; Australian Council of Midwives, 2023)—evidence that policy can sustain compassion.

Even within exhaustion, renewal begins quietly. Small acts of reconnection - a shared meal, a karakia, or returned ritual – become signs of reweaving. The return to muka cord ties embodies this restoration. Traditionally made from harakeke and used to tie the pito, muka carries both physical function and spiritual significance. Simmonds (2017) explains that muka, whenua-ki-te-whenua and karakia at birth are acts of ancestral continuity and decolonisation, grounding pēpi and whānau in whakapapa and restoring the tapu of Te Whare Tangata.

Today, muka is recognised even in clinical settings: Lakes District Health Board (2020a) endorses its use, linking it to Te Tiriti. Lawrie et al. (2024) shows wāhine Māori seek tikanga even during caesarean birth, desiring muka, respectful handling of pēpi and whenua, and spiritual ceremony despite medical constraint. This is not nostalgia, but sovereignty made tangible—a blueprint for how tikanga can flourish in contemporary care settings.

The mantle of tohungatanga — karakia, intuition, wānanga, and relational ethics — once risked prosecution under the Tohunga Suppression Act 1907. Its repeal in 1962 did not end the silencing. The legacy lingers in the marginalisation of wairua and rongoā. Marsden (2003) describes tohunga as vessels through which atua act. Mead (2016) reminds us of the obligations to uphold tapu and maintain harmony. Keelan-Peebles (2022) calls Māori midwifery a spiritually grounded practice, where wairua and tikanga form the ethical spine. For some, this means declining practices that feel misaligned. Tohungatanga is not a role but a covenant of humility, service, and guardianship.

Spirituality, as midwives affirm globally, is inseparable from practice (Linhares, 2012; Kızılca Çakaloz et al., 2023). Linhares (2012) argues, “It’s your birth, your power” — affirming the autonomy of the birthing person and the midwife’s spiritual presence as guide and protector. Leuluai’s (2018) He Tamaiti Tapu framework highlights mana atua, mana whenua, and mana tangata as foundations of child wellbeing. In birthing, mana atua restores sacredness, mana whenua anchors practice in genealogical connection with the land and mana tangata affirms belonging. Together, these principles show Indigenous birthing knowledge not as revival but as assertion of mana motuhake.

This subchapter affirms the hinge: the midwife’s spirituality and the sanctity of Te Whare Tangata rise together. Wairua-informed care is constitutional, ethical and clinically imperative; when centered, healing becomes generational. Wairua lives through maramataka, whakapapa, whanaungatanga, and ritual observance. When excluded, wāhine Māori face

trauma and disconnection; when honoured, the whiri are rewoven. Despite the mamae and symbolic violence, this is not reclamation but return — it lives in our bones, in the voices that call, in the hands that heal, in the breath of those who remember — weaving the whāriki anew through kōrero and collective care.

As we close, we return to the midwife, her body the vessel, her wairua the channel through which Te Whare Tangata is protected. Every intuitive act offered with integrity contributes to this guardianship of the womb. Rangahau affirms that practitioners with strong spiritual health deliver better spiritual care (Hu et al., 2025), while reflective practice builds resilience against burnout (Attard et al., 2020). To be a Māori midwife is to embody wairua in practice: seeing Te Whare Tangata not as anatomy but as a cosmological portal where whakapapa and atua converge.

Te Wakahuia o Hine is more than a rōpū; it is a vessel of remembering, weaving the whāriki anew beneath the moon of Hine-te-Iwaiwa. Under her gaze and guided by our tupuna, we lay strands for those yet to arrive. These insights reveal both fragility and resilience in Māori midwifery and name the systemic gaps that remain. This discussion involves rangahau questions two and three, showing how the absence of spiritually safe practice depletes both wāhine and midwives, and how mentorship and values-based practice can begin to restore balance. Subchapter 2.6 gathers these threads as waiata — sealing the pōwhiri and preparing the way into the wharekai of methodology.

2.6 Ko te ringarehe: He kōrero whakakapi. The skilled hang - gaps, synthesis and pathways forward.

To complete the whāriki of this review, we step back to view the woven pattern in full — where threads hold strong, where they fray, and where new weaving must begin. This subchapter gathers the strands of Chapter Two, identifying what is known, obscured, and reawakened as Te Whare Tangata is restored as a site of sovereignty and wellbeing.

Each section laid down threads that together, reveal both strength and rupture. The theoretical foundations of Kaupapa Māori, Mana Wāhine, and wairuatanga affirm Indigenous authority over reproductive wellbeing while exposing constitutional breaches that continue to marginalise wāhine Māori (Mikaere, 2011; Tupara & Tahere, 2020). Te Whare Tangata was restored as cosmological site of divine transmission, where pūrākau, oriori, maramataka, and embodied practice confirm wairua as foundational in maternity care (Marsden, 2003; Pere, 1991; Rameka, 2015). Tracing colonisation and biomedical dominance revealed how spiritual dimensions were disrupted—how atua were displaced by surveillance and collective wisdom

suppressed (Clarke, 2012; Kenney, 2011; Lawrie et al., 2024). Through lived experience, the reclamation of Indigenous birthing knowledge also illuminated both the cost of navigating colonised systems and the emergence of collectives such as Te Wakahuia o Hine, grounded in integrity, intuition, and whakapapa (Tupara & Tahere, 2020).

Together these insights affirm that wairuatanga is not a cultural addition but the first breath of the birthing space—the unseen hand guiding intuitive practice and the constitutional promise of tino rangatiratanga in maternal health (Durie, 1998; Potter & Simmonds, 2024). Interwoven through this is mauri—the life force binding wairua, hinengaro and tinana, animating the body and carrying ancestral memory (Mead, 2016; Ngāpō & Kingi, 2024). When wairua is diminished, mauri unsettles, leaving wāhine and pēpi vulnerable across generations (Marsh, 2019; Semmons, 2006). Restoration of both is essential if Te Whare Tangata is to remain a source of vitality and whakapapa survival.

Despite this richness, critical gaps persist. Wairua and mauri are affirmed across Māori and Indigenous literatures yet remain fragmented within mainstream scholarship. Clinical research seldom integrates them as epistemological or spiritual foundations of birth. Even where cultural safety is acknowledged, wairuatanga and mauri are rarely embedded in policy, training, or regulation. Practices such as karakia, mirimiri, or maramataka-aligned timing are upheld in communities but not institutionally, despite their constitutional grounding under Te Tiriti.

Another gap lies in the absence of metrics for spiritual safety. Mortality and morbidity are routinely measured, yet no validated tools assess whether maternity environments upheld wairua, mauri and relational integrity. This silence conflicts with obligations under the Health Practitioners Competence Assurance Act and Tūranga Kaupapa, the mandatory cultural competency framework for midwifery (Ngā Māia Trust, 2025). Without indicators that recognise spiritual flourishing, inequities remain biomedicalised and breaches of Te Tiriti obscured. Equally, this review affirms that the midwife's wairua cannot be separated from Te Whare Tangata: her spirit is both shield and channel, sustaining the sacredness of birth.

Whānau are actively restoring birthing tikanga — through karanga, oriori, whenua burial, atua-led decision-making and other acts of wairua sovereignty. Yet these practices remain largely undocumented and their transformative impact on birthing outcomes and systems change is often invisible in mainstream research. The realities of the Māori midwifery workforce are also underexplored. Research seldom captures the cultural and spiritual load carried by Māori midwives, the depletion of wairua and mauri through institutional resistance, or the resilience

required to sustain practice. Collective recovery strategies such as tuakana–teina mentorship, whānau-based support and cultural-spiritual renewal are vital yet insufficiently theorised.

Equally absent is quantified Kaupapa Māori rangahau bridging mātauranga and science. Epigenetic studies confirm that maternal stress, nutrition, and environment leave molecular imprints persisting across generations (Feinberg, 2018; Nilsson et al., 2018), yet no studies examine how tikanga such as karakia, wai rākau, or oriori act as protective factors. Muka cord ties have been widely reclaimed and stated as taonga tuku iho (Best, 1975; Papakura, 1986; Simmonds, 2017), but have not been evaluated through Kaupapa Māori clinical trials evidencing their healing potential. These omissions reveal an enduring reluctance to recognise Māori knowledge systems as legitimate clinical science.

The rangahau priorities identified by Te Aukume a Hine-te-Iwaiwa [TAaHtI]—including workforce development, rongoā integration, perinatal wellbeing, and clinical trials on Kaupapa Māori postpartum anaemia management, muka cord ties and omphalitis—define a Kaupapa Māori agenda for maternal and infant wellbeing. While ON TRACK Network provides a collaborative platform, TAaHtI's framework ensures rangahau remains grounded in mātauranga and Tiriti-based obligations. Māori-led rangahau is therefore not supplementary but essential to the national perinatal agenda, aligning with PMMRC (2024) recommendations to address anaemia, prematurity and perinatal infection as leading preventable inequities.

The workforce itself reveals further fragilities. As seen in recent industrial action and stalled pay-equity reforms, the wellbeing of the midwifery and wider caring workforce mirrors systemic imbalance—when relational and spiritual labour are undervalued, both professional and public mauri are compromised. Section ninety-four continues to fund midwifery through a fee-for-service model, yet kaiawhina, Rongoā practitioners, hapū wānanga and lactation consultants remain inconsistently resourced or excluded, despite being integral to whānau-centered maternity ecosystems. This inequity perpetuates burnout among midwives carrying these responsibilities without support. The lack of an equivalent funding model for lactation consultants is especially concerning, as ūkaipōtanga is both cultural covenant and clinical determinant of infant wellbeing (Edwards, 2014; Reinfelds, 2015). These realities reinforce PMMRC calls to strengthen postnatal safety, breastfeeding continuation and supports TAaHtI's focus on perinatal wellbeing as Kaupapa Māori and national priority.

Another key framework for midwives is the Children's Act 2014 (formerly the Vulnerable Children's Act), which requires health professionals to protect tamariki from abuse and neglect. From a te ao Māori perspective, this duty begins in hapūtanga, recognising the wellbeing of pēpi as inseparable from that of their māmā. Upholding the Act's intent therefore

means ensuring systems that hapū māmā engage with are culturally safe, spiritually grounded, and Tiriti-honouring. For Māori midwives, safeguarding Te Whare Tangata is itself child protection: by preserving the womb's spiritual integrity, they protect the whakapapa of future generations.

When midwives respect whānau mana, they fulfil statutory obligations while enacting wairua-based protection that law alone cannot capture. If workforce structures erode the wairua of midwives, the tapu of Te Whare Tangata is compromised; when spiritually supported—through supervision, collective care, and Kaupapa Māori practice—they uphold both their own wellbeing and the constitutional protections owed to wāhine and pēpi.

Sustainable practice models remain under-developed. The 24/7 Lead Maternity Carer model continues to drive attrition (Brettkelly, 2025; Capper et al., 2022). In 2024, I conceptualised a Midwifery collective rotation across antenatal, intrapartum, postnatal and leave periods in thirteen-week blocks—an untested but promising design. Its absence in both literature and implementation underscores the need for Kaupapa Māori innovation in workforce structures and rangahau into collective models that reduce burnout and strengthen continuity of care. Alongside remuneration, diversification of income streams remains unmet: Māori midwives are tied to precarious contracts while revenue from ACC-funded rongoā treatments, facilitating hapū wānanga or digital antenatal education, and rangahau consultancy is rarely systematised, leaving the workforce financially fragile and limiting whānau-led care.

Mentorship and supervision are similarly under-resourced. Social work treats supervision as essential and remunerated (Aotearoa New Zealand Association of Social Workers 2024); in midwifery it is inconsistent and often unpaid. For Māori midwives carrying disproportionate cultural loading, the absence of funded tuakana–teina supervision deepens isolation and spiritual depletion. Embedding Kaupapa Māori supervision would honour both the reflective obligations of the Annual Practicing Certificate [APC] process and the cultural-safety commitments enshrined in Tūranga Kaupapa. Postgraduate pathways also remain fragmented, with little support for midwives to specialise in counselling for birth trauma, pelvic-floor recovery, perinatal mental health, or Kaupapa Māori parenting—areas where PMMRC (2024) reports identify persistent gaps.

Another neglected area is the development of spirituality within health professionals. International frameworks identify spirituality as central to holistic care (Attard et al., 2020; Hu et al., 2025), yet few studies evaluate programmes that strengthen practitioners' spiritual wellbeing. Without investing in the wairua of the workforce, the wairua of Te Whare Tangata remains vulnerable. Embedding Kaupapa Māori models of spiritual development in education,

supervision and postgraduate training is therefore essential, enabling midwives to carry karakia, reflection and intuition with integrity.

For whānau, access to culturally congruent services remains uneven. Midwifery care ends at six weeks postnatally, leaving families without weekly professional guidance during the entire "fourth trimester." Family Centers once offered such support, providing advice on breastfeeding, infant care, and positive parenting (Plunket, 2025), but few equivalents now exist within midwifery spaces where whānau already hold trusted relationships. Dedicated Kaupapa Māori fourth-trimester clinics would align with PMMRC calls to strengthen postnatal care and with TAaHtI's priority on perinatal wellbeing.

Beyond the clinic, digital access is minimal. Māori-led channels, podcasts, and apps could extend antenatal and postnatal education into homes, while a national map of hapūtanga and wahakura wānanga would help reconnect whānau to tikanga as part of their birthing journey. These initiatives embody whakawhanaungatanga within Tūranga Kaupapa and Te Tiriti commitments.

Finally, decolonising Māori midwifery requires dismantling the hierarchies that reproduce harm. Māori midwives stand at the interface of te ao Māori, biomedical obstetrics, and feminist midwifery (Mikaere, 2011; Simmonds, 2011)—a role both empowering and precarious. Where once women healers were persecuted as witches (Ehrenreich & English, 2010; Federici, 2004), today they face encountering symbolic silencing disguised as professional critique, - forms of institutional control that inflict psychological injury and foster unsafe, spiritually corrosive work environments (Bourque Bearskin et al., 2024; Johnston, 2005; Pezaro et al., 2016; Thapar-Björkert et al., 2016). Decolonisation is thus not only reclaiming tikanga and wairua but dismantling internalised hierarchies that fray the whāriki from within.

To locate these silences and opportunities, Table 2.6.1 summarises the major gaps identified across the literature and outlines how Te Whāriki o Hine-te-Iwaiwa provides a methodological bridge between ancestral knowledge, contemporary practice, and policy reform.

Table 2.6.1: Summary of literature gaps and thesis response.

Identified gap in exisiting literature	Supporting sources	How this thesis responds/contributes
Absence of explicit inquiry into wairuatanga within clinical maternity care and midwifery scholarship.	Mikaere (2011); Simmonds (2011); Clarke (2012); Tupara & Tahere (2020)	Centers wairuatanga as constitutional, clinical, and spiritual imperative within midwifery practice; develops a wairua-led analytic model grounded in Te Whāriki o Hine-te-Iwaiwa.

Limited documentation of community-led and marae-based birthing models that privilege spiritual nourishment and safety.	Tupara & Tahere (2020); Gabel (2021); Pihama et al. (2014).	Provides original empirical evidence from marae-based wānanga and positions the marae as whare wānanga of intergenerational restoration.
Lack of frameworks integrating Mana wāhine and wairuatanga into midwifery rangahau design.	Mikaere (2017); Pihama (2001); Simmonds (2011).	Introduces Te Whāriki o Hine-te-Iwaiwa as an Indigenous methodological innovation that unites cosmology, ethics, and method.
Marginalisation of rongoā Māori and spiritual practices (karakia, maramataka) as "complementary" rather than constitutional to care.	Mark (2012); Waitangi Tribunal (2011); NZCOM (2018).	Re-positions rongoā and maramataka as legitimate, Treaty-protected clinical and spiritual practices.
Limited exploration of spiritual development and wellbeing of midwives themselves.	Attard et al. (2020); Hu et al. (2025); Davies et al. (2022).	Develops the concept of the spiritually safe midwife (Chapter 2.5), showing how reflective and wairua-centered practice sustains Te Whare Tangata.
Absence of quantitative or Kaupapa Māori rangahau connecting wairua-based practices to biological outcomes (e.g., epigenetics).	Feinberg (2018); Nilsson et al. (2018); Heke (2021).	Aligns mātauranga Māori with epigenetic evidence to propose future interdisciplinary rangahau bridging ceremony and science.
Lack of structural analysis linking spiritual disconnection to breaches of Te Tiriti and systemic inequities.	Waitangi Tribunal (2019, 2023a); Rae et al. (2023).	Demonstrates that exclusion of wairua from maternity systems constitutes ongoing Te Tiriti breaches and proposes spiritual redress.
Sparse rangahau on Māori midwifery workforce sustainability and wairua protection.	Capper et al. (2022); Tupara & Tahere (2020); Pihema et al. (2023)	Identifies structural inequities and advocates for tuakana–teina supervision, collective funding, and Kaupapa Māori mentorship models.

Taken together, these gaps reaffirm that investment in Kaupapa Māori rangahau, integrated funding models, workforce sustainability, mentorship, postgraduate development, and equitable consumer access are not aspirational extras but constitutional and professional obligations. They align directly with TAaHTI Kaupapa Māori rangahau priorities, PMMRC recommendations reported to the Health and Disability Commissioner, the cultural-safety requirements of the Midwifery Council's (2024d) APC process, and Tūranga Kaupapa as the profession's mandated competency framework. Viewed through Te Tiriti, these are not optional reforms but necessary acts of redress.

Chapter Two has therefore laid the theoretical and spiritual foundations of this thesis. It restores birth as a cosmological event where atua, whakapapa, and wairua converge, revealing how colonisation severed spiritual authority from birthing spaces and produced disconnection, symbolic violence and depletion. It also shows how these ruptures echo through whakapapa via epigenetics and intergenerational pathways, confirming that wairua and mauri are constitutional imperatives under Te Tiriti - protective dimensions detailed through Kaupapa Māori rangahau, tupuna practices and whānau-led care. This thesis responds to these silences by repositioning wairuatanga and mauri as central to maternal and infant wellbeing — not as soft outcomes, but as constitutional, clinical and spiritual imperatives.

Te Whāriki o Hine-te-Iwaiwa, the woven foundation of this thesis, is now laid and honoured for what it has endured – its fibres weathered by colonisation, its pattern still visible, its mauri unbroken. Strengthened through reflection, it rests within the wharenui, awaiting our return. Those who come to learn from it - researcher, reader and whānau — must first step into the wharekai to whakanoa: to reflect, replenish and prepare the spirit for the sacred work ahead.

The pōwhiri sequence now moves from ātea to wharekai. Chapter Three is the metaphysical meal that nourishes this journey—where the wairua of the work pauses to shift between ceremony and wānanga, deepen relationships, digest knowledge and replenish collective mauri before returning to the wharenui in Chapter Four to continue the weaving of Te Whāriki o Hine-te-Iwaiwa with whānau.

Chapter Three: He ara rangahau | Te wharekai o Te Whāriki o Hine-te-Iwaiwa: Methodology and ethical Pathways | The house of nourishment and preparation.

Te wharekai is a metaphysical house of sustenance and reflection, enabling movement between the spiritual and physical realms of this thesis. Here, tikanga, wairua and ethical intention combine as ingredients that feed the rangahau and steer the researcher. This is where the kaupapa is prepared for the sacred work ahead: Te Whāriki o Hine-te-Iwaiwa becomes both vessel and guide, blending knowledge, care and accountability. This chapter is a space of whakanoa and whakawhanaungatanga, where theory becomes practice, relationships are woven, and the spiritual and methodological integrity of the rangahau is grounded before entering the wharenui of findings.

3.1 Te Whakanoa | Crossing into Te Wharekai: From the ātea of theory to the wharekai – lifting tapu and preparing for wānanga.

Chapter Three offers the reader a taste of how these elements and methodologies combine to sustain the rangahau and assist the analysis that follows. This methodology is guided by an intention set at the beginning of my rangahau haerenga — that this thesis contributes to the whakapapa of mātauranga of Hine-te-Iwaiwa, who presides over Te Whare Pora and Te Whare Tangata - interrelated realms of sacred creation, discipline, and responsibility (Marsden, 2003; Mead, 2016).

Before birth became institutionalised, these houses held equal significance — weaving and birthing together safeguarding whānau and whakapapa. The same pou that anchor Te Whare Pora — wairua, mauri, mana, and whakapapa — stand also within Te Whare Kōhanga, uniting both as houses of creation. Kākahu, taura, and whāriki woven for marriage, conception, and birth carried this protective role. To support whānau to birth pēpi is to stand within Te Whare Pora, where the midwife weaves spiritual protection, cultural guidance, and clinical skill. Birthing is a form of weaving — drawing together atua and whenua, tupuna and uri, threading the continuity of whakapapa into te ao mārama (Marsden, 2003).

This chapter lays down Te Whāriki o Hine-te-Iwaiwa as the methodological framework and provides a clear route from paradigm to practice. It locates this rangahau within a Kaupapa Māori paradigm (ontology–epistemology–axiology–method), framed by Mana wāhine and postcolonial critique, and enacts a pōwhiri logic to prepare reader and researcher for the wānanga that follows (Cram & Adcock, 2022; Mahuika & Mahuika, 2020; Shay et al., 2022).

The roadmap of chapter Three outlines: 3.2 - paradigm and positionality; 3.3 - Te Whāriki o Hine-te-Iwaiwa as methodological scaffold; 3.4 - rangahau design (marae-based wānanga,

consent, analysis, data sovereignty); 3.5–3.7 - recruitment, data collection, and analysis; 3.8–3.10 - ethics, rigour, and limitations; with 3.11 - transition to findings.

Although the mātauranga of Hine-te-Iwaiwa is ancient, colonisation has placed rifts within her whāriki (Pihama, 2001; Simmonds, 2011) To navigate these ruptures, I position Matariki as a methodological compass— informed by Polynesian wayfinding that charts by whētu, marama, winds and oceanic currents across Te Moananui-a-Kiwa (Finney, 1994; Harding, 1997). Within Matariki, I attend especially to Pōhutukawa, the eldest whetū daughter of Matariki, associated with remembrance (Matamua, 2017). Here, I set intentions to connect with the māmā and tūpuna I descend from, whose whispered guidance draws new horizons within reach where our whānau can flourish.

Wayfinding becomes methodological practice: I scheduled ‘navigation checks during data generation and analysis— iterative orientations that read signs, tracked maramataka phases, and adjust course (Moleni, 2020). Reflection points, like stars for the navigator, aligned direction with purpose and place (Almond, 2019). Valentine et al. (2017) remind us that in te ao Māori, wairua is relational and boundaryless - a legitimate mode of knowing that orients the work toward whakapapa flourishing. This decolonial indigenist stance treats participants as co-knowers, privileging Māori language, frames, and resists extractivism (Ned, et al., 2022).

The underpinning methodology is a relational cultural act, multifaceted in nature. Long before formal approval was received, the internal kaupapa was already heard and responded to — guiding how each stage would unfold. This approach enabled the research to speak multiple languages: academic and ethical, spiritual and familial, ensuring that whānau, researcher, and reader were brought together in a shared field of learning. In doing so, it established a culturally grounded mode of engagement — a model of mātauranga transmission that can be carried forward and adapted by others in the future.

A writing method is one of proximity – as if we sit beside the whāriki, tracing its pattern and wave, engaging in kōrero layered with pūrākau, tikanga, and wairua. The intention is that readers feel resonance and enter their own internal wānanga, interpretating what it means for their whānau and practice. Because many Māori practitioners care across whakapapa lines, knowledge transmission must be both intimate and expansive — grounding practitioners in their own whakapapa while enabling careful transportation into wider whānau contexts, always centered on whānau Māori wellbeing.

Finally, this section sets the bearings for what follows: drawing on Cram & Adcock’s (2022) community-up values (e.g., aroha ki te tangata, he kanohi kitea, manaaki ki te tangata, kia tūpato), the chapter establishes the ontological, epistemic, relational and methodological

settings of the study and connects the rangahau aims to the procedures detailed in the sections ahead.

In essence, Chapter Three is both compass and meal — a place of whakanoa and preparation where the wairua of Hine-te-Iwaiwa infuses every methodological choice. It nourishes the kaupapa so that what follows in te wharenui may be received with clarity, humility, and intact mauri.

3.2 Te kaupapa rangahau | Positioning the rangahau paradigm and researcher: Locating ontology, epistemology, axiology and positionality within Kaupapa Māori and Mana Wāhine frames.

Moving from nourishment to navigation, this section grounds the research in its philosophical home. The rangahau is grounded in Kaupapa Māori methodology (Cram & Adcock, 2022; Smith, 2012), informed by Mana Wāhine theory (Mikaere, 2011; Simmonds, 2011), and shaped by a postcolonial critique of how colonisation continues to structure maternity care in Aotearoa (Came et al., 2019b; Johnston, 2005; Mikaere, 2005). Indigenous grounded ontologies center relational being, knowing, and doing, emphasising accountability to local knowledge holders (Shay et al., 2022). Kaupapa Māori as praxis, holds value only when it remains accountable to whānau, hapū and iwi and produces tangible outcomes (Cram & Adcock, 2022).

This paradigm affirms that knowledge is not neutral – it is always relational, embodied, and accountable. My methodological stance is therefore both intellectual and spiritual: to stand in whakapapa as kaupapa, to privilege Māori worldviews as legitimate science and to recognise wairua as a valid epistemic dimension of rangahau integrity.

As an insider researcher, my whakapapa connects me to Hiruharama Marae. Some participants were whānau I had cared for as a midwife; others were unknown until this wānanga. This insider–outsider continuum made whakawhanaungatanga and aroha ki te tangata essential to building trust and spiritual safety (Bishop, 1998; Cram, 2001; Rewi, 2014). I acknowledge the “space-between” dynamics of positionality and commit to ongoing reflexivity (Dwyer & Buckle, 2022). My credibility rests not in titles but in whakapapa to the kaupapa — what Smith (1997) calls the ‘organic intellectual,’ one who moves between academic and community spaces while remaining accountable to the collective.

Reflexivity has been a wānanga practice rather than a technical exercise. I engaged in reflective journaling through the maramataka, recalibrating direction during low-energy phases and affirming purpose during expansive ones. Rather than a detached log, these reflections

became a living conversation with tupuna, atua wāhine, and my supervisors—a constellation of guidance ensuring that every decision carried both academic and wairua validity.

I did not maintain a stand-alone decision log; instead, reflexive practice occurred before, during, and after each wānanga or analysis session. Scheduling and procedural adjustments were made intuitively and relationally, guided by marae tikanga, maramataka, and the realities of working full-time and whānau life. Evidence of these choices exists as dated diary notes, calendar records, text communications with supervisors, and versioned materials that together form an auditable trail supporting dependability and confirmability of analysis.

My position is evidenced through praxis. Over the past decade I have stood within and alongside multiple kaupapa advancing Mana Wāhine and whānau sovereignty—through Ngā Māia ki Tāmaki Makaurau [NMkTM], Ngā Māia o Aotearoa me Te Waipounamu, Te Wakahuia o Hine, and He Hono Wāhine. Each role has been both service and ritual – continuing the lineage of Māori midwifery leadership (Gabel, 2013; Tūpara, 2009) and embodying the Mana Wāhine tradition that recognises wāhine as tapu, guardians of whakapapa, and political leaders (Wilson, 2017). As Smith (1997) reminds us, Kaupapa Māori must be activated through praxis – lived, accountable, and community-grounded. These roles are tangible expressions of theory-in-action: kaupapa, wānanga, and leadership that move beyond abstraction into collective transformation.

Through Ngā Māia initiatives and regional health roles, I helped embed Kaupapa Māori maternal services that reconnected whānau to whenua, whakapapa, and rongoā, integrating hapū wānanga and SUDI prevention across communities (RNZ, 2021; Te Rūnanganui o Ngāti Porou, 2024). This work exemplified a methodology in motion—where service design, cultural revitalisation, and research converged as a continuum of healing (Muriwai et al., 2015; Reweti, 2023).

Digital presence of similar kaupapa through Kia Kaha Māmā extends this mahi into online and whānau spaces, supporting wāhine through maramataka, and decolonizing wellbeing. Nationally I have contributed to Māori maternal advocacy, rangahau, and education—including the Mātātuhi Whakatere a Hine-te-Iwaiwa report (Ware et al., 2023), SUDI resource updates (Healthify, 2025), promotion of breastfeeding and the impacts on hauora from the rising costs of living (Atkins, 2022; Gisborne Herald, 2023), and co-presented internationally on Māori Midwifery, Maternities and Research priorities (ON TRACK Network, 2023; Tupara et al., 2022, 2023). These contributions represent visible manifestation of praxis- rangahau as service, service as ritual, ritual as continuing education.

My re-indigenisation journey is also shaped by repatriating my whakapapa with te reo and strengthening my whānau through decolonial workshops that open pathways to indigenizing

practice (Tūpuna Parenting, n.d.). These experiences unfold within enduring postcolonial realities where legislation such as the Midwives Act 1904 and Tohunga Suppression Act 1907 displaced Māori midwifery and rongoā, privileging biomedical hierarchies that persist today (Came et al., 2019b; Kenney, 2011).

Gendered structures within medicine (MacMillan, 2012) and persistent stereotypes (Venables, 2018) continue to marginalise Māori practitioners, while institutional racism and suppression of tikanga remain embedded in health systems. Universalist feminism has also silenced Indigenous women (Parashar, 2017); in Aotearoa, Mana Wāhine has often been overlooked within midwifery discourse (Gabel, 2013; Tūpara, 2009). Jenkins and Pihama (2001) state Mana Wāhine as mātauranga in its own right, yet the ongoing classification of rongoā as "complementary" medicine reflects colonial hierarchies of legitimacy (Royal Australasian College of Physicians, 2019). My stance therefore aligns with decolonial and Indigenist principles of relational accountability, language revitalisation, and consent that resist extractive logics (Ned et al., 2022).

Navigating systemic inequities is part of the mantle I carry and a key reason this study works through Kaupapa Māori, Mana Wāhine, and postcolonial frames. As Smith (1997) reminds us, accountability in Kaupapa Māori rangahau requires praxis—transformation that is visible in the work we do.

Titles and positions alone cannot quantify contribution; only whakapapa to the mahi and tangible outputs demonstrate leadership. When people speak about Kaupapa Māori theory, I am reminded of Graham Smith's (1997) challenge: 'Show me the blisters on your hands.' It is through these calluses of service and resilience that my methodology is made real – a living manifestation of wairua, work, and whakapapa interwoven.

3.3 Te Whāriki o Hine-te-Iwaiwa | Methodological framework: The woven foundation – principles, strands and practice logic of the framework.

This thesis is grounded in Te Whāriki o Hine-te-Iwaiwa, a woven methodology drawing upon cosmology, pūrākau, Mana Wāhine theory, post-colonial critique and whānau-centered rangahau practice. It acknowledges that rangahau, like birth, is not only intellectual but also spiritual, physical, emotional and relational. In this sense, I am the māmā and this thesis the pēpi — carried with the same tikanga that safeguards whakapapa and sustains hauora, each page a contraction, each insight a breath of hā, each recommendation an oriori verse.

The framework is woven from multiple strands. Cosmology and pūrākau locate Te Whare Tangata, as a portal through which whakapapa continues (Cram & Adcock, 2022; Dixon, 2013; Watene, 2025). Mana Wāhine centers wāhine as carriers of authority and tapu, while post-

colonial critique exposes and resists the cultural invasion that sought to silence wāhine voices (Jenkins & Pihama, 2001; Mikaere, 2011). My lived experience as a Māori midwife, māmā, and researcher interweaves clinical realities, whānau narratives, and scholarship, detailing Kaupapa Māori rangahau is not a method to apply, but a tikanga to be lived (Pihama et al., 2015; Smith, 2021).

This framework is expressed through the acronym HINE TE IWAIWA, each letter representing a thread of her whāriki, woven from cosmology, tikanga, and lived reality into both philosophy and method. It operationalises Cram & Adcock's (2022) community-up ethics (e.g., aroha ki te tangata, he kanohi kitea, manaaki ki te tangata, kia tūpato) within a grounded Indigenous ontology (Shay et al., 2022), translating paradigm into practice for recruitment, encounter design, consent, analysis, data governance and dissemination.

H – Hā | Breath as rhythm and regulator:

Hā is the rhythm of life linking the individual to atua, environment and planetary breath (Brown & Reihana-Morunga, 2020). Methodologically, I treated hā as the project's breath — the rhythm opening and closing each stage through karakia, intentional pauses and wai breaks. Hā-moments were built into wānanga design to regulate mauri and sustain spiritual equilibrium. When energy dropped, I paused the process, like a midwife guarding the perineum during crowning, gently guiding transition to reveal the taonga, ensuring balance and protection for all.

I – Ikura, Ira tangata | Cycles and continuities:

My ikura cycles and the maramataka served as the internal clock of this thesis, carrying me from Te Kore through Te Pō, into Te Ao Mārama. Recognising myself as ira tangata, located analysis within whakapapa, acknowledging intergenerational trauma and resilience (George & Ngamu, 2020). Methodologically, lunar and ikura rhythms guided scheduling, journalling and interpretation, ensuring analytical decisions honoured embodied knowing. Quiet phases invited reflection; expansive phases invited writing in action – mirroring the small bursts of energy in postnatal recovery and transition through the fourth trimester.

N – Ngā tikanga o te whakawhānau | Cultural science of birth:

Horizontal tikanga such as whanaungatanga, manaakitanga, mihimihi, and whakawhetai refer to the everyday relational practices that sustain balance between people. Vertical tikanga such as karakia, waiata, pūrākau, and whakapapa connect participants to atua and ancestral realms. Together, they form the cross-weave of this whāriki — Indigenous sciences that stabilise wairua, regulate cortisol, and affirm identity (August, 2004; Ritchie, 2021). Each encounter followed a tikanga sequence: whakawhanaungatanga → karakia → kōrero →

closing karakia, supported by koha, the option of a support person, and whānau-first returns — where findings and insights were shared back to participants and their whānau before wider dissemination. This rhythm mirrored the flow of a birth plan: preparation, intensity, and release back into noa.

E – Eketia te ahurangi | ascending and returning knowledge:

This principle reflects the poutama pathway of enlightenment, where knowledge ascends to kauae runga and returns to kauae raro, carrying responsibility for collective wellbeing (Marsden, 2016; Mead, 2003). Reflection within wānanga ensures kōrero strengthens rather than diminishes whakapapa (Forster, 2022), embodying cultural safety as spiritual safety (Ramsden, 2000). Each ascent of understanding required a descent into humility — re-grounding with whānau, supervisors, or kaumātua to keep the mahi tika.

T – Te Whare Tangata | Sacred house of humanity:

Te Whare Tangata is both anatomical and cosmological (Dixon, 2013; Henry, 2015). Colonisation fractured its guardianship but reclaiming it restores clinical and spiritual integrity. Protecting Te Whare Tangata becomes both shield and sanctuary (Jenkins & Pihama, 2001). Methodologically, kaitiakitanga shaped data sovereignty, ensuring kōrero and whakapapa were handled with dignity, stored securely, and returned first to the whānau who birthed them. Every transcript was treated as a living whenua — to be buried, blessed, or re-read only under consent.

E – E tu i to ake rangatiratanga | Standing in sovereignty:

This principle affirms tino rangatiratanga and mana motuhake. It required confronting self-doubt, exhaustion, and institutional power while standing staunchly in Māori authority. Participant agency was upheld through iterative consent, transcript review, and choice over naming or anonymity. Mana Wāhine critiques universalist feminism and centers wāhine Māori realities (Farnham, 2025; Gabel, 2005; Kenney, 2011b; Jenkins & Pihama, 2001; Mikaere, 2005). Analysis resisted deficit framings, restoring Mana Wāhine as the organising logic. Advocacy and truth-telling were balanced with rangimārie — peace born of integrity — ensuring our mokopuna inherit aspiration, not bitterness.

I – Ihi me te wehi | Vital force and reverence:

Ihi is vitality; wehi awe. Together they describe the energetic forces enlivening encounters. Colonisation sought to mute these forces, pathologising wāhine bodies and silencing their sacred authority (Mikaere, 2022). In this study, ihi me te wehi became method: opening and closing with karakia, attending to silences, and using micro-consents to protect wairua. This

was midwifery logic in rangahau form – listening for surges of energy and responding with breath, stillness or karakia before proceeding.

W – Waiariki | Sacred waters:

Waiariki embodies the cleansing and restorative power of water (Ahuriri-Driscoll, 2014; Marsden, 2003). Through the maramataka, wai carries rhythmic wisdom guiding wellbeing (Hikuroa, 2017; Warbrick et al., 2023). My support of hydrotherapy during labour, water births – including my own anchor this understanding – that water heals and flows. In rangahau practice, wai was used to whakanoa after sensitive kōrero: participants were invited to cleanse with wai tapu, walk to and connect within the awa, reaffirming mauri, mana, identity and closure.

A – Amaia | Lunar arc and rest:

Amaia, the lunar rainbow connects to Hina and cycles of rest and renewal. Tracking the maramataka guided time management and safeguarded hauora, ensuring work unfolded in divine timing. By syncing analytical sprints with expansive moon phases and honouring new moon with rest, I resisted capitalist productivity rhythms and aligned instead with Indigenous temporality.

I – Iho | Cord of connection:

The iho sustains life in the womb and symbolises connection between tinana, whenua, and wairua. Practicing muka tying and whenua burial anchors identity and continuity (Jenkins & Mountain Harte, 2011; Simmonds, 2017). Rongoā enhances wellbeing through whānau, whenua, and wairua (Marques et al., 2022), while epigenetic rangahau illustrates maternal experience imprints across generations (Nilsson et al., 2018; Migicovsky & Kovalchuk, 2011). Methodologically, iho guides consent and stewardship – every kōrero a living cord between researcher and participant, never severed without ceremony. Consent was relational and ongoing; participants could pass, pause or withdraw, co-deciding anonymity and naming. Data returned first to whānau, honouring that knowledge, like the iho, belongs to its source.

W – Whakawhetai | Reciprocity and gratitude:

Whakawhetai is the cloak of gratitude and reciprocity, calling for humility between teaching and learner, tuakana and teina (Te Aho Matua, 2008). In practice, I enacted whakawhetai through koha, timely thanks and plain-language returns. When participants arrived bearing kai or their tamariki, their trust became koha, and that koha expressed manaakitanga. I matched their generosity with transparency, honouring utu – the ethic of balanced exchange that keeps the rangahau relationship alive beyond the page.

A – Ariā | Manifestations of atua presence:

Ariā are the visual expressions of atua knowledge (Dell, 2021a; Heke, 2023). They remind us that Māori rangahau and midwifery are both traditional and contemporary Indigenous sciences – rigorous, innovative, and sovereign (Tupara & Tahere, 2020). Every theme or metaphor in this thesis is treated as a living ariā - not an abstract label, but an embodiment of atua voice. Protecting ariā means safeguarding the living wairua of kaupapa, so it may guide future mokopuna in rangahau and practice (Dell et al., 2021b; Dell et al., 2024).

Table 3.3.1: Methodological summary of Te Whāriki o Hine-te-Iwaiwa in practice
(Author's own, 2025)

Kaupapa principle	**Practical action in rangahau**	**Ethical & cultural principle enacted**	**Intended outcome/ contribution**
Whakapapa: Connection	Grounded the study at Hiruharama Marae within personal and ancestral whakapapa; participants invited through whakapapa networks.	Tika & Mana (NEAC, 2024); Aroha ki te tangata (Cram & Adcock, 2022).	Upholds whānau authority and local governance; ensures accountability to hapū and whenua.
Kaupapa Māori – By Māori, for Māori	Designed a marae-based wānanga method; used te reo Māori concepts throughout; returned kōrero to whānau first.	Tino rangatiratanga (Te Tiriti Article 2); Māori data sovereignty.	Creates culturally legitimate, self-determined knowledge; strengthens Indigenous rangahau autonomy.
Mana Wāhine – Authority of Wāhine	Centered wāhine voices; enabled choice over naming or anonymity; applied micro-consents and gentle topic shifts.	Manaakitanga & Whakawhanaungatanga; community-up ethics.	Protects participants' tapu and authority; restores wāhine agency in rangahau and midwifery.
Wairuatanga – Spiritual Integrity	Opened / closed wānanga with karakia, waiata, and wai cleansing; aligned timing with maramataka; created after-care plan (rongoā/kaumātua/clinical).	Tapu / Noa balance; Kia tūpato (care)	Safeguards mauri and emotional safety; integrates spiritual and ethical wellbeing.
Maramataka – Cyclical time and Reflection	Scheduled wānanga and analysis phases to align with expansive lunar periods; used reflective	Pono (honesty) & Whakapono (faith); iterative reflexivity.	Promotes hauora and rangahau rhythm; enhances rigour through

	journals as navigation checks.		timing and self-alignment.
Whakawhanaungatanga – Relational Engagement	Recruited via kanohi-ki-te-kanohi and online pānui; maintained ongoing communication and koha reciprocity.	He kanohi kitea, Manaaki ki te tangata.	Builds trust and mana-enhancing relationships; ensures participant engagement is reciprocal and respectful.
Tikanga – Correct Practice	Applied tikanga sequence (pōwhiri → karakia → kōrero → kai → whakanoa → wai cleansing → karakia whakamutunga).	Whakawhanaungatanga, Manaakitanga, Whakawhetai.	Embeds Māori ethical standards; creates spiritually and culturally safe encounters.
Te Whāriki o Hine-te-Iwaiwa – Woven Framework	Operationalised through HINE TE IWAIWA strands (Hā, Ihi me te Wehi, Waiariki, Amaia etc.); each strand translated into procedures.	Kaupapa Māori ontology → epistemology → axiology → method alignment.	Demonstrates integrated cosmology, ethics, and method; advances Indigenous midwifery methodology.
Reflexivity – Praxis and Learning	Kept diary notes, emails and versioned files; met with supervisors and kaumātua for review.	Pono, Whakapono, and Mana motuhake (accountability and self-determination).	Ensures auditability and confirmability; positions rangahau as living praxis.
Reciprocity – Whakawhetai and Koha	Provided participant packs and koha; shared plain-language summaries; returned findings to all participants.	Whakawhetai / Utu / Koha (ethics of gratitude and balance).	Strengthens relational ethics; ensures benefits extend beyond academic outcomes.

Together these strands form a complete whāriki — a cosmological, ethical, and methodological framework where theory and practice are interwoven. They guided decisions in recruitment, encounter design, analysis, and dissemination, aligning with the CONSIDER framework of Huria et al., (2019) and community-up ethics (Cram & Adcock, 2022).

Rigour was upheld through multiple layers of accountability and relational practice. Credibility was maintained through participant checks and tuakana–teina review, ensuring interpretations were affirmed and refined within trusted relationships (Bishop, 1998). Transferability was strengthened by detailed descriptions of the marae context, enabling readers to locate findings within lived Māori realities and relational environments (Cram, 2001; Walsh-Tapiata, 2003).

Dependability was supported through dated field diaries and maramataka-based reflection, grounding analytic rhythm in temporal and spiritual cycles (Boardsworth et al., 2024). Confirmability was maintained through reflexive journalling, karakia, and transparent boundaries between data and interpretation—practices aligned with Māori ethical frameworks such as Te Ara Tika that privilege relational integrity, reciprocity, and cultural safety (Bishop, 1998; Boardsworth et al., 2024). Collectively, these interwoven processes ensure methodological soundness while honouring Kaupapa Māori expectations of wairua balance, accountability, and collective validation.

As a Mārama Advanced Practitioner of Tūranga Kaupapa (Ngā Maia Trust, 2025), I locate this thesis within an ancestral continuum of care: Tūranga Kaupapa defines our professional ethics; Te Whāriki o Hine-te-Iwaiwa sustains wairua. One safeguards practice; the other nourishes wairua.

In sum, Te Whāriki o Hine-te-Iwaiwa is both blueprint and compass — a living weave of kawa and tikanga, rongoā and taonga-ā-waha, mātauranga Māori and modern science. It reminds us that rangahau, like birth, is ceremony — each stage guided by atua, each outcome returning to whānau and every thread leading back to wairua.

3.4 Hoahoa rangahau | Research design: Marae-based wānanga, tikanga-anchored procedures, and Māori data sovereignty.

This rangahau adopted a qualitative, Kaupapa Māori design, anchored in the wairuatanga of Te Whare Tangata and guided by Te Whāriki o Hine-te-Iwaiwa as its methodological framework. Kaupapa Māori ensures that rangahau is by, with and for Māori (Cram & Adcock, 2022), affirming Māori ways of knowing as rigorous and legitimate, while protecting against colonial research practices that have historically silenced Mana Wāhine and undermined whānau wellbeing (Pihama, 2001; Mikaere, 2011).

Each procedural strand of Te Whāriki o Hine-te-Iwaiwa was enacted through the design — from whakawhanaungatanga-based recruitment and maramataka-aligned timing to karakia-framed encounters, participant-led consent, transcript review, and whānau-first dissemination. This ensured the framework was lived, not symbolic, aligning with CONSIDER (Huria et al., 2019) and community-up ethics (Cram & Adcock, 2022).

Methodology was treated as ceremony: a movement through karanga, pōwhiri, whakawhānaungatanga, kōrero, kai, and whakanoa—each stage protecting mauri, cultivating trust, and upholding wairua safety. It was both logical and necessary to return to a marae setting where tikanga, whakapapa, and wairua could hold the kaupapa. Marae are recognised

as sites of healing and intergenerational learning where collective identity is enacted (Durie, 2007; Gillies & Barnett, 2012).

For this study, a marae within Te Aitanga a Materoa hāpu, was not an abstract venue but my tūrangawaewae - the resting place of my tupuna, the receival site of my moko kauae and source of spiritual sustenance. The marae thus functioned as an ancestral collaborator – a living infrastructure of knowledge transmission where kauae runga meets kauae raro.

Although the Participant Information Sheet signalled a mihi whakatau, the haukāinga responded to the wairua of the moment, choosing a shortened pōwhiri — karanga, whaikōrero, waiata on the ātea, followed by whakawhanaungatanga, karakia, and kai to whakanoa. This adaptation upheld mana whenua authority, collective accountability, and wairua safety. This adaptation upheld mana whenua authority, collective accountability and wairua safety (Durie, 2007).

The data collection method was wānanga — the traditional mode of collective learning and knowledge exchange for Māori. Wānanga emphasise collective dialogue, oral tradition, and critical reflection, disrupting Western binaries of researcher and researched while centring iwi aspirations and tikanga (Mahuika & Mahuika, 2020). In this study, wānanga was not a focus group but a sacred encounter reviving ancient pedagogies where the spiritual, emotional, and intellectual are inseparable. Wānanga also reflects how Māori rangahau is initiated and sustained — through whanaungatanga, whakapapa, and kanohi kitea (Rewi, 2014).

Cross-cultural guidance similarly affirms cultural sensibility in access, consent, and flexibility (Pelzang & Hutchinson, 2022). These principles were embodied through participant-led scheduling, plain-language materials, and iterative consent. Tikanga shaped each stage: pōwhiri to open, karakia to protect, kai for reciprocity, pūrākau for intergenerational knowledge, and—where needed—awa cleansing or night-sky observation to restore balance. These were not symbolic additions but methodological imperatives creating āhurutanga and collective governance of knowledge.

Participant Design and Sampling Logic:

A minimum of ten and a maximum of fifteen whānau were to be recruited, with adult members (18+) identifying as wāhine/tāne (not yet parents), wāhine/tāne with tamariki, kuia/kaumātua, or maternity kaimahi. Tamariki could attend but were not included as participants. Wānanga were conducted as audio-recorded, semi-structured group kōrero under marae tikanga; individual interviews were an optional backup for those unable to attend or where additional depth was needed.

This design aligns with national standards for Māori research ethics. NEAC (2012) defines four Māori rangahau principles — whakapapa, tika, manaakitanga, and mana — which shaped this study. The Health Research Council Act 1990 mandates attention to Māori health, and the HRC's (2019) Māori Health Advancement Guidelines emphasise relationships, significance, rangahau team, and rangahau characteristics. Reporting and processes also followed CONSIDER (Huria et al., 2019) and community-up ethics (Cram & Adcock, 2022).

These principles were enacted through whakapapa-aware consent, participant choice over naming or anonymity, iterative transcript review and withdrawal rights, appropriate koha and hospitality – kai, accommodation, tamariki care and participant packs, and whānau-first dissemination under Māori data sovereignty.

Tikanga as evidence-informed practice:

This design affirms Indigenous science as evidence-based and valid. Traditional Māori practices such as muka ties, karakia, waiata, and rongoā are recognised within te ao Māori as promoting balance and wellbeing (Tupara, 2017). These practices correspond with physiological mechanisms documented in contemporary rangahau — including stress reduction, heart-rate regulation and oxytocin release — that underpin safe labour and postpartum recovery (Kang et al., 2018; Leppänen, 2018; Ratima & Crengle, 2013). While the physiological impacts of tikanga have not yet been quantified, evidence from singing, relational bonding and culturally grounded care supports these parallels. Contemporary studies further highlight the contribution of rongoā to whānau-centered wellbeing, with growing recognition across the health system (ACC, 2023; Keats-Farr, 2022; Koea et al., 2024).

Holding wānanga on the marae also enacted rights affirmed in the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP, 2007), including tino rangatiratanga, free prior informed consent, and the right to maintain and strengthen Indigenous institutions, practices and knowledge systems.

By integrating Kaupapa Māori design, marae as a living healing space, wānanga as method, and tikanga as process within national and international ethical frameworks, this rangahau embodies both rigour and wairua. Whānau voices are protected, amplified and woven back into Te Whāriki o Hine-te-Iwaiwa.

Analytic pathways and rangahau questions:

In this thesis, the HINE TE IWAIWA methodological framework served as the analytical seed. The guiding questions were:

1. What constitutes the wairuatanga of Te Whare Tangata in contemporary practice?

2. How do tikanga, maramataka, and rongoā operate methodologically and clinically?
3. In what ways do colonial dynamics persist, and how are they resisted through Mana Wāhine practice?
4. What practice, education and policy implications emerge for Māori midwifery?

Each question corresponded to data generated through marae-based wānanga with wāhine and whānau, analysed through Mana Wāhine and post-colonial lenses, and interpreted via the HINE TE IWAIWA strands with tuakana-teina review and participant summary checks. See Appendix F to read the questions used during wānanga to answer the guiding questions recorded above.

Analytical movement followed an oceanic rhythm – immersion (tikanga-framed listening) → inductive coding → thematic weaving → cultural review → participant verification → synthesis into practice implications. Dependability was demonstrated through dated journals, calendars, and versioned materials; confirmed by transparent separation between data and interpretation alongside reflexive accounting of my role.

Delimitations and Limitations:

Delimitations ensured kaupapa fit and feasibility: marae-based wānanga in Tairāwhiti; adult participants with whakapapa ties to the kaupapa; and focus on maternity contexts. Limitations included contextual specificity (transferability rather than generalisability), role-duality bias, and maramataka-aligned timing. These were mitigated through thick description, composite phrasing in small communities, participant control over transcripts and naming, and iterative consent. Timeframes were adapted in harmony with life, moon, and whānau - privileging āhurutanga over academic haste and trusting that right timing is itself a measure of rigour.

Ethical alignment:

Ethical approval (AUTEC Ref 24/41) was granted prior to data generation, aligning with NEAC (2012), HRC (2019), and UNDRIP (2007). Consent was relational and ongoing, supported by an after-care plan (rongoā/kaumātua/clinical options) and built-in opportunities for rest and reflection. See Appendix A for approved ethics.

Kōrero are treated as taonga under Māori data sovereignty: collected on a minimum-necessary basis, stored securely in encrypted repositories within Aotearoa, and returned first to whānau in plain language. Any reuse beyond the thesis requires renewed consent. This approach enacts the principle that knowledge, like a newborn, must first be placed back in the arms of its whānau before being presented to the world.

3.5 Te tīmatanga o te haerenga | Recruitment and participant engagement: Whakapapa-led selection and kanohi-ki-te-kanohi relational ethics.

Recruitment was grounded in Kaupapa Māori ethics—whanaungatanga, manaakitanga, and aroha-ki-te-tangata—and guided by Auckland University Technology Ethics Committee [AUTEC] approval (Ref 24/41, 22 October 2024–21 October 2027) for Tapu i te wā hapū: Exploring the wairuatanga of Te Whare Tangata.

The approved plan authorised a multi-pathway recruitment through a visually consistent pānui, carrying the AUT logo, ethics number, criteria, and contact details for researcher and supervisor. The pānui was shared through the researcher's personal and professional Kia Kaha Māmā social-media pages (Facebook, Instagram, LinkedIn), website, and whakapapa-based community pages (Te Aowera and Hiruharama Marae). This ensured transparency and wide visibility while remaining firmly within Māori communication networks. See Appendix B, C, & D.

During ethical review, AUTEC required the removal of a Google "expression-of-interest" form. The amendment ensured that whānau contacted the researcher directly via private message or email, maintaining privacy and enacting whanaungatanga from the outset - a human conversation rather than an online transaction.

Relational process of invitation:

The invitation followed a two-step process:

1. The researcher provided the Patient Information Sheet and Consent form
2. Participants were given at least fourteen days to consider participation before confirming. Follow-up occurred only through the participant's preferred channel of contact (email, private message, text, in person), maintaining autonomy and safety.

Recruitment drew on whakapapa and marae networks in Te Tairāwhiti. The ethics application identified Te Aowera Marae as the primary venue and Hiruharama Marae as contingency. Introductions were framed through whakapapa – naming whānau lines and acknowledging the haukāinga – so the invitation became a karanga rather than a cold call. Public posts on marae pages reiterated this connection, locating the researcher genealogically and extending a mana-enhancing, opt-in pathway for participation. Due to venue cost constraints, the wānanga was held at the approved contingency venue; Hiruharama Marae, remaining within AUTEC parameters.

Eligibility criteria matched AUTEC approval: Māori adults (18+) who had given birth, or who had supported a birth as whānau or kaimahi, or were kuia or kaumātua. Tamariki were welcome but not included as participants.

After expressing interest, participants observed a fourteen-day consideration period before providing informed consent, either electronically or in person. All participants chose to sign consent in person on the day of the wānanga. The researcher photographed each form and emailed it securely to the supervisor to upload into AUT's restricted cloud storage, separate from rangahau data. Access was limited to the researcher and supervisor. Participants retained the first two pages containing study information, the researcher held the signed originals, stored in a locked cabinet for at least the next six years, in accordance with AUT's Research Data Storage Guideline (Auckland University of Technology [AUT], 2023). This dual system – digital for accountability, physical for whakapapa stewardship – mirrored the dual realms of kauae raro and kauae runga.

Reach and engagement:

The ethically approved pānui achieved strong and meaningful engagement across multiple digital platforms, reflecting both professional and whakapapa-based reach. These analytics were taken from the Meta Business Suite dashboard, as both my Facebook and Instagram accounts are interconnected, their reach and engagement metrics reflect combined audience data rather than distinct totals for each channels.

- Facebook and Instagram;
    - Kia Kaha Māmā via Meta business suite: the boosted pānui reached 1,129 people and achieved 1,579 video views, with 3 likes, 3 interactions, and 2 new followers. The majority of engagement (91%) came from wāhine aged 25-44 years, indicating alignment with the target participant group.
    - Hiruharama Marae: received 34 reactions and 9 comments, several of which expressed interest or confirmed participation in the wānanga;
    - Te Aowera Marae: received 13 reactions, extending the call across interconnected whakapapa networks and East Coast communities.
- LinkedIn (Kaniwa Kupenga-Tamarama): achieved 346 impressions, reaching 104 members, with 14 reactions, 1 comment and 1 repost by the Women's Health Action Trust, amplifying visibility across professional health and maternity networks.

Across all platforms, the combined reach exceeded 2,600 people, with more than 1,600 direct views. Engagement spanned professional, academic, and whānau audiences — bridging

digital and relational spheres. This online visibility functioned as a modern karanga across the digital ātea, calling wāhine and whānau ready to stand in the kaupapa.

Engagement remained relational, not anonymous. Participants responded through private messages or kanohi-ki-te-kanohi conversations, often opening with shared whakapapa connections or personal birth experiences. Following these interactions, the researcher personally provided information sheets and consent forms, ensuring informed and mana-enhancing participation. Every exchange was a miniature pōwhiri — introductions, listening, and mutual acknowledgement before formal agreement. See Appendix E.

Outcome of recruitment:

Through these relational and digital threads, the rangahau successfully recruited seven participants—two kuia, three wāhine, and two tāne—who attended the rangahau wānanga. Another two wāhine who expressed interest chose not to consent but still supported the day by assisting with kai and caring for tamariki.

Although smaller than the anticipated ten-fifteen participants, this intimate rōpū created depth, safety and wānanga quality where every voice was heard and every silence respected. Professional participation was intentionally limited to 20% to protect whānau voice; in practice, no registered health professionals attended, which further centered whānau realities. Several participants held backgrounds in community or wellbeing work, bringing valuable intersections of lived and professional experience. The resulting group was both diverse and connected – a microcosm of hāpu knowledge exchange, cross-generational and gender-inclusive, and reflective of wānanga as collective learning.

Cultural and data-management integrity:

Recruitment and consent procedures met AUTEC requirements for privacy, secure storage, and data retention, while upholding Māori data sovereignty. All audio data and documents are stored within AUT's encrypted rangahau repository for six years; with consent forms and data kept separate, and accessible only to the researcher and supervisor.

More importantly, each participant retained spiritual ownership of their kōrero. Data were treated as taonga — to be listened to, protected, and eventually returned home- ensuring that rangahau remained in service to whānau, not the institution.

Summary:

In keeping with Kaupapa Māori values, recruitment became an act of weaving — connecting people, places, and wairua around a shared intention to restore the sacredness of Te Whare Tangata. It was a methodological karanga that travelled through whakapapa and wifi alike, drawing in those who heard the call of Hine-te-Iwaiwa. Digital tools extended reach, but

whakawhanaungatanga anchored trust. By the time participants arrived at the marae, the relationship was already woven, the wānanga began as whānau returning home rather than subjects entering a study.

3.6 Ngā mahi o te wānanga | Data collection process: Wānanga as method – karakia, kai, pūrākau, and collective knowledge exchange.

Data was gathered through a one-day wānanga held at Hiruharama Marae. The wānanga began with a pōwhiri led by haukāinga, followed by karakia, whakawhanaungatanga, and, after the kōrero, kai in the wharekai to whakanoa the rōpū. The following morning opened with karakia before sunrise, grounding the wānanga in wairua and reaffirming the tapu of the kaupapa.

The rhythm of the day followed tikanga and the mauri of those present. Rather than a rigid timetable, the wānanga flowed with participants' and tamariki needs, guided by the natural pulse of the marae – birdsong before dawn, the hum of kōrero, play and laughter. Kai breaks arose organically, led by whānau rather than schedule. Activities for tamariki: colouring, rugby balls, and digital games – kept the space inclusive and relaxed while maintaining focus on the kaupapa.

The wānanga unfolded as collective kōrero, interweaving pūrākau, lived experience, and intergenerational reflection. Participant packs were gifted to each whānau member, containing A5 notebooks, pens, lollies, sunflower seeds harvested from the researcher's garden, a small whatū tukutuku panel to weave, tumbleweeds gathered from the coastline of Tūranganui-a-Kiwa, and a road-found cleaned Kārearea feather.

Each taonga carried symbolic intent:

- Sunflower seeds: growth and optimism, new light after darkness.
- Tukutuku threads: the weave of whakapapa and *wānanga* knowledge.
- Tumbleweed: endurance and adaptability through change.
- Kārearea feather: spiritual protection, courage, and clarity of sight.

These were not decorative inclusions but ritual instruments – anchors connecting participants to whenua, atua and their own whakapapa. Holding and weaving them created embodied engagement; the wānanga became both conversation and ceremony.

At the close of the day, the rōpū gathered for collective reflection, waiata, and a karakia whakamutunga to restore balance and release tapu. We then walked together to the Waitakaro awa, entering its cool waters for cleansing and renewal. The awa was not a symbolic backdrop

but a participant in the rangahau – a living relative carrying away heaviness and restoring mauri. Standing knee-deep in the Waitakaro awa, we acknowledged Hikurangi maunga, called to our tupuna, and felt the current remind us that flow, not force, sustains life.

Later that evening, once tamariki were settled, we reconvened beneath the night sky for shared pūrākau and stargazing. Using a telescope, we observed Jupiter and its moons, a moment expanding the wānanga beyond whenua into the cosmic realms of Ranginui. Pūrākau of naming tamaiti, whakapapa, and celestial rhythms reaffirming that maternity and birth are interdimensional acts linking atua, tupuna, and uri across realms.

The wānanga traversed all domains of being – from the wharenui to the wharekai, to the awa and the heavens – echoing the cosmic architecture of Te Whare Tangata itself. Each moment enacted connection: land, water, sky and body as one continuum of creation and learning.

Recording and transcription:

Kōrero was audio-recorded on two devices to ensure clarity and back-up, with my phone linked to a Yeti microphone as the primary recorder. I had sought ethical approval to video the wānanga to capture gesture, silence, and body language – the unspoken parts of collective communication – but this was not approved by AUTEC. While the absence of video limited the ability to analyse non-verbal knowledge, it protected confidentiality and aligned with tikanga, reminding me that some wairua knowledge is meant to be felt, not archived.

Transcription followed a kaupapa-based and whānau-led process. I trialled Māori transcription software Kaituhi, but its limited recognition of dialect and bilingual phrasing required extensive correction. I instead subcontracted two whānau members – each signing confidentiality agreements. This ensured the process remained relational, accountable, and infused with aroha, rather than outsourced to strangers.

During transcription, our whānau also navigated the tangihanga of my uncle. Grief and mahi became intertwined, reflecting the real context of Māori rangahau – that life and loss move through the same current. Rather than a disruption, it became part of the wānanga cycle, reinforcing that every act of writing and analysis is also an act of remembrance.

Data integrity and relational practice:

Throughout, tikanga governed data handling:

- All devices were cleared and encrypted after upload to AUT's secure OneDrive.
- Consent forms were held separately in locked storage.
- Raw audio remains accessible only to the researcher and supervisors.

- Transcripts are de-identified but retain whakapapa nuance through composite phrasing.

Every step honoured kaitiakitanga –guardianship of participants' kōrero as taonga. Each recording was treated as living breath, not data; each voice as *mauri* to be returned to its rightful source.

In these ways, data collection was both practical and spiritual, interweaving tikanga, whakapapa, and wairua with the technicalities of recording and transcription. The wānanga extended across wharenui, wharekai, and ranginui – illuminating that rangahau on Te Whare Tangata must itself be held within spaces where atua, tupuna and whānau are present and active.

3.7 Te tātari kaupapa | Data analysis: Kaupapa Māori and Mana Wāhine thematic analysis within Te Whāriki o Hine-te-Iwaiwa.

Analysis of the wānanga kōrero followed Braun and Clarke's (2006, 2014) six phases of thematic analysis – familiarisation, coding, generating themes, reviewing, refining, and writing. Each phase was undertaken through the interpretative lenses of Kaupapa Māori, Mana Wāhine (Simmonds & Gabel, 2019), and post-colonial critique (Broughton, 2016). Rather than dissecting transcripts as data, I approached each kōrero as taonga: living repositories of whakapapa, wairua, and mauri that demanded care, accountability, and ritual protection throughout the analytic process.

Immersion and Familiarisation:

The analysis began with immersion. I re-listened to audio recordings and re-read transcripts repeatedly to feel the rhythm of the kōrero, not just the words. I listened as a midwife listens to a labouring mother – for breath, for pauses, and the spaces where insight begins to crown. Coding was both descriptive and intuitive, capturing repeated patterns and emotional cues. I paid attention to tone, silence, hesitation and laughter – the subtle vibrations that reveal the mauri of the kōrero. Early memos recorded tohu or sensations (e.g. warmth, tears, goosebumps), acknowledging wairua as interpretive presence rather than bias.

Transcription and initial coding:

I trialled ChatGPT for early word-frequency clustering of anonymised transcripts – a technical aid for initial organisation – but all interpretation remained manual. Digital tools can sort words, but they cannot read wairua, metaphor, or irony in te reo Māori. Only human reflexivity, steeped in whakapapa, could hold that depth of knowing.

Following familiarisation, I developed iterative coding documents: an initial descriptive table, a secondary thematic table, and a final analytical framework. This layering resembled weaving a whāriki – laying foundations, tightening the weave, and checking for pattern coherence.

Theme development:

Theme generation was guided by metaphors of weaving, whakapapa, and pattern recognition within Te Whāriki o Hine-te-Iwaiwa. Each theme was conceptualised as an aho- distinct yet interdependent within the overall weave.

Draft themes were presented to supervisors who provided feedback to deepen whānau voice and refine coherence. After further analysis and engagement with the literature, the theme reached a state of holistic satisfaction and saturation. Kōrero with trusted colleagues in Māori midwifery and Kaupapa Māori rangahau acted as peer debriefing and cultural verification, ensuring tikanga integrity. Each theme was tested for resonance rather than reduction: did it carry the vibration of truth? Could whānau see themselves reflected in it? This was the threshold for inclusion. See Appendix G, Table G.1 for intermediate coding and theme development and Table G.2 for the final thematic framework model.

From themes to whāriki:

Themes were then woven into conceptual clusters that reflected both rupture and restoration:

- Disconnection of wairua in clinical spaces
- Sacredness of Te Whare Tangata and birthing as ceremony
- The midwife as kaitiaki wairua
- Whānau as the original healing collective
- Wānanga as transformative reclamation

These themes revealed how colonisation continues to influence maternity experiences through institutional bias, racism and gendered hierachies (Adcock, 2024; Shepherd, 2024). Yet alongside these ruptures, acts of resistance and renewal emerged – whānau-led births, spiritual reclamation and embodied expressions of Mana Wāhine. Pain was not framed as deficit, but as whakapapa trace – a scar that tells the story of survival and points toward collective healing.

Reflexivity and spiritual accountability:

Throughout the analytical process, I maintained a stance of whakaaro. Reflexive journalling, maramataka alignment and karakia served as accountability rituals. Before each analysis session, I recited a short karakia, to clear energy and invite guidance from atua wāhine.

Afterward, I wrote a closing note of whakawhetai, acknowledging the kōrero as living taonga, not text.

My positionality as both Māori midwife and researcher shaped the interpretation. Rather than detaching from this duality, I embraced it as epistemological strength – standing in the in-between space as both analyst and witness, translating lived spiritual intelligence into academic language without diminishing its tapu.

From wānanga to writing:

The movement from wānanga to written findings mirrored the transition from pōwhiri to wharekai – a shift from ceremony into collective nourishment. The written analysis became a form of kai, offering sustenance to those who would read and carry it forward.

In writing, I sought not only to describe what was said but to transmit what was felt – the vibration of ancestral memory carried through voices that still echo. This is the work of te tātari kaupapa: to braid intellect, intuition and wairua into one coherent fabric of meaning.

3.8 Ngā tikanga matatika | Ethical Pathways: Relational consent, after-care planning, and alignment with AUTEC and UNDRIP principles.

This rangahau was approved by AUTEC (Ref. 24/41). Ethical principles were enacted through Te Tiriti obligations of kāwanatanga, tino rangatiratanga, ōritetanga, and wairuatanga (NEAC, 2022). These were not abstract ideals but lived throughout the rangahau haerenga – woven into karakia, kōrero, decision-making, and accountability to whānau and haukāinga.

Dual governance and local authority:

I initially sought “location ethics” approval through Ngati Porou Oranga [NPO] while employed there. However, my employment concluded before the wānanga occurred. After kōrero with supervisors and kaumātua, it was agreed that the kaupapa would proceed under AUTEC’s approval and marae authority, without progressing the NPO application. This upheld local tino rangatiratanga, affirming that rangahau on ancestral whenua must be governed first by whakapapa and relationships, not institutional boundaries.

While NPO represents the broader iwi collective, it does not directly speak for the whānau, marae, or hāpu. Governance therefore rested with those whose whenua and wharenui held the kaupapa – the haukainga and whānau of Hiruharama marae. This reflected Kaupapa Māori ethics grounded in whanaungantanga, kaitiakitanga and accountability to place.

Relational consent and participant rights:

Consent processes were transparent, iterative and designed to protect tapu. Participants were given fourteen days to consider involvement, could withdraw upto the coding phase, and were

invited to review findings before submission. Consent forms outlined rights and responsibilities, with participation remaining entirely voluntary.

Consent was treated as a living relationship rather than a single signature – revisited through kōrero, micro-consents before sensitive topics, and collective affirmation at the wānanga's opening and closing. This mirrored tikanga forms of ongoing agreement, where aroha-ki-te-tangata and manaakitanga guide informed participation.

Data was de-identified, with physical copies stored securely and digital files held in AUT's encrypted OneDrive. Retention for six years meets AUTEC policy and aligns with Māori data-sovereignty principles that prioritise controlled access, transparency, and return of findings to whānau.

Manaakitanga and reciprocity:

Koha acknowledged whānau contributions, including marae hospitality and taonga valued up to $35 per participant. Additional expression of manaakitanga included shared kai, provision for tamariki, whānau accommodation and sustained communication before and after the wānanga. These gestures were not administrative niceties but ethical necessities- maintaining spiritual equilibrium and signaled gratitude. They embodied NEAC's (2012, 2024) Māori rangahau ethics principles of whakapapa, tika, manaakitanga, and mana as lived ethics rather than procedural compliance.

A key ethical negotiation around data capture reaffirmed that some wairua-borne knowledge is meant to be experienced rather than archived — a reminder that ethical integrity in Kaupapa Māori rangahau is measured not by documentation, but by the mauri left intact.

Alignment with indigenous and national frameworks:

This rangahau upheld the Health Research Council Act (1990), the Māori Health Advancement Guidelines (2019), and UNDRIP (2007) by ensuring that participants retained authority over their kōrero, and knew they were able to withdraw at any time up until coding and that findings were returned first to whānau in plain language — an act of whakawhetai and whakapapa closure.

Ethics as living practice:

Ethics were not a hurdle to clear before rangahau but a living process carried through every breath of the kaupapa. Each karakia, each pause or adaptation, each shared cup of tea was an ethical act — recalibrating the balance between tapu and noa, participant and researcher, spirit and structure.

In sum, ethical practice in this study was embodied through tikanga that protected mauri, reciprocity that upheld mana and governance that centered whakapapa. Together, these elements ensured the kaupapa remained spiritually safe, culturally accountable, and institutionally robust — a model of tikanga matatika where Te Tiriti, UNDRIP, and Te Whāriki o Hine-te-Iwaiwa converge in practice.

3.9 Te tika me te pono | Rigour and trustworthiness: Credibility, transferability, dependability, confirmability, and spiritual integrity.

Rigour in this study was not measured through detached notions of objectivity, but through Kaupapa Māori values that recognise knowledge as relational, embodied and accountable. The principles of tika, pono, whakapono, and manaakitanga formed the foundation of methodological integrity, enacted throughout the rangahau.

Tika – appropriateness and cultural fit:

Tika guided the rangahau design to ensure the kaupapa was appropriate, beneficial and aligned with tikanga and whānau aspirations. Each decision was tested against a single question: “does this uplift the mana of the kaupapa and the people it serves?”. When uncertainty arose, reflection, karakia and consultation with supervisors or kaumātua restored direction. This value kept the rangahau oriented toward kaupapa tika – ethical, context-specific and spiritually safe.

Pono – honestly and transparency:

Pono required honesty in process and positionality. I named my dual role as Māori midwife and researcher not as a conflict but as an authentic expression of Kaupapa Māori praxis – where theory and service coexist. Reflexive notes captures personal reactions, challenges, and insights after each wānanga or analysis session. Transparency extended to communication with participants, who were kept informed of progress and invited to review findings prior to submission.

Whakapono – trust and relationship accountability:

Whakapono was enacted through trust built with participants and haukāinga. This trust was spiritual as much as professional – a shared confidence that our combined intentions would produce something healing and useful. Participants were assured that their kōrero would be represented faithfully, with their wairua intact, and that findings would be returned first in accessible form. Ongoing reciprocity through koha, updates and plain-language returns, demonstrated this trust in action.

Manaakitanga – care and reciprocity:

Manaakitanga underpinned the relational ethics of care sustaining the kaupapa. It was expressed through koha, kai, emotional attentiveness, and the gentle pacing of kōrero during wānanga. Rituals of opening and closing with karakia, time for grounding, and whānau support for tamariki formed part of a methodological rigour grounded in compassion.

Reflexivity and wairua integrity:

Trustworthiness was upheld through whakaaroaro—deep reflection guided by the maramataka. I recognized how my own wairua and life rhythms shaped engagement with the data, working during expansive lunar phases and resting during new moon periods. This reflexive rhythm, consistent with Kaupapa Māori methodology, maintained balance and kept me accountable to whānau and tupuna.

Cultural validation and member checking:

Validation occurred both within and beyond the formal wānanga. Participants questioned the "end game" of the kaupapa, co-shaping directions for practice and dissemination. These interactions acted as living peer-review — a communal vetting process rooted in whanaungatanga rather than academia. Informal follow-ups in community spaces continued the relationship and allowed feedback, while returning final summaries for review ensured cultural credibility and collective ownership of outcomes.

Braiding rigour; Credibility, transferability, dependability, confirmability:

Rigour was expressed through the four conventional qualitative standards, each re-interpreted through a Māori lens:

Table 3.9.1: Summary of rigour.

Conventional Criterion	Kaupapa Māori Expression	Evidence in Practice
Credibility	He kanohi kitea — authenticity and visibility	Participant feedback, tuakana–teina review, iterative consent
Transferability	Whakawhanaungatanga — relational resonance	Thick description of marae context, whānau engagement, and tikanga detail
Dependability	Pūmau ki te kaupapa — consistency with intent	Dated journals, emails, and maramataka-aligned process trail

Confirmability	Kaitiakitanga o te kōrero — stewardship of voice	Clear separation between data and interpretation; reflexive audit trail

By grounding these measures in Māori values, rigour became a living quality rather than a compliance checklist — ensuring that both the method and mauri remained in balance.

Integrity as harmony:

Ultimately, the trustworthiness of this rangahau rests on mauri tau — the calm coherence achieved when ethics, analysis, and intent are aligned. When wānanga participants described feeling “lighter” after sharing their stories, that was evidence of integrity: the rangahau had not extracted, it had healed. By embedding tikanga, practicing reciprocity, and sustaining reflexivity, the study upheld both scholarly and spiritual rigour.

In this way, Te tika me te pono transcends methodological formality — it becomes karakia in action, binding pono, tika, and whakapono, so that the mauri of the kaupapa remains strong long after the rangahau is complete.

3.10 Ngā herenga | Limitations and delimitations: Contextual specificity, maramataka timing, and role duality reflexivity.

As with all rangahau, this study carried limitations that must be acknowledged. The most immediate was the smaller-than-anticipated sample size. While the design aimed for ten-fifteen participants across whānau and professional roles, the final wānanga brought together seven participants: two kuia, three wāhine and two tāne. All the wāhine and kuia present had given birth and the tāne had supported the births of their pēpi. This reduced breadth but deepened intimacy, wairua safety and intergenerational reflection. The small rōpū allowed a healing pace of sharing where every voice could be held with care.

Participants reflected on diverse community and wellbeing experiences. The absence of registered health professionals – though unplanned – centered whānau realities and the grassroots labour of care sustaining Māori wellbeing. This intimacy returned the kaupapa to its heart: whānau as the first health system, healers as those who listen, feed, nurture and restore balance within the collective, ‘the ones pēpi and māmā go home too’.

A limitation arose around data capture, as AUTEC permitted audio but not video recording, restricting analysis of gesture and silence; this outcome reaffirmed that some *wairua* knowledge is meant to be experienced rather than archived. In practice, I compensated by re-listening to recordings and journalling intuitive impressions, letting rhythm and emotion guide interpretation. These listening rituals, often accompanied by karakia, became a way of recovering what could not be seen.

Scope and delimitation:

Delimitations ensured the kaupapa remained focused and achievable. The rangahau was confined to a marae-based wānanga in Tairāwhiti, engaging adult Māori participants connected through whakapapa to the kaupapa and centering maternity contexts. Rather than generalizability, transferability was sought through thick contextual description and transparent process trails that provided depth and rigour.

Timeframes followed the maramataka, prioritising wairua safety and whānau wellbeing over linear progress. When energy waned, I rested, when tides of energy rose, I wrote. In this way, timing itself became a methodology – a rhythm of reciprocity between researcher and kaupapa.

Limitations were mitigated through reflexivity, composite phrasing for small-community anonymity, and whānau-first review of transcripts and findings. These approaches upheld dependability, relational safety, and alignment with Kaupapa Māori principles.

Holding the edges with grace:

In acknowledging limitation, I also acknowledge the grace within it – the humility to accept that no rangahau can capture the totality of an experience. This project is a single thread within a much larger whāriki of mātauranga and Mana Wāhine.

The strength of this thesis lies not in scale but in honesty. By naming constraint and continuing with compassion, I honor the deeper ethic of the kaupapa: that rangahau, like birth, does not need perfection – only presence, integrity and breath.

3.11 He otinga | Closing the meal and preparing for wānanga returning to the whāriki: Transitioning from methodology to findings within te wharenui.

This chapter has enhanced the earlier chapters by offering manaakitanga to whakanoa and ground the rangahau in Kaupapa Māori, Mana Wāhine, and post-colonial critique — now woven through the framework of HINE TE IWAIWA. It prepares the additions to be rewoven into her whāriki, resting within the wharenui from my positionality and kaitiaki as a Māori midwife, researcher, and māmā, carrying whakapapa, responsibility, and lived experience into her design.

Within Te Whāriki o Hine-te-Iwaiwa, methodology was not a checklist but a ceremony — each act of wānanga, karakia, kai, and reflection a strand in the weave of ethical and spiritual practice. Through this, the rangahau became both vessel and compass, aligning scholarship with wairua and returning mana to Te Whare Tangata.

As the metaphysical meal is finished, whānau begin to enter the wharenui, carrying the soft chatter and shifting energy of transition. Having shared the kai of methodology — prepared with aroha and served with care — our wairua and puku are replenished. The whakanoa has lifted the ceremonial tapu; what remains is gratitude and readiness.

As we rise from this table, I invite our whānau into the wharenui to begin the sacred conversation of Te Whāriki o Hine-te-Iwaiwa. The nourishment of this chapter travels with us — steadying the spirit as we cross the courtyard into Chapter Four, where whānau voices take their place within the weave.

Chapter Four: Ngā kōrero a te whānau o Te Whare Tangata | Findings and thematic Analysis: The house of dialogue and reflection.

We return into the wharenui—with our full puku, hearts and mind open to explore, discuss and receive the lived experiences of whānau. Here, we embark on a guided tour through Te Whāriki o Hine-te-Iwaiwa, inspecting, feeling and understanding her weave. Together, we sit with the whānau who entrusted their kōrero, re-examining the state of those threads: where they remain strong, where they have been frayed by colonisation and disconnection, and where new strands of mātauranga are being rewoven.

This chapter presents the findings of Tapu i te wā hapū, shaped through kōrero shared during marae-based wānanga. Guided by Kaupapa Māori, Mana Wāhine and wairua-led paradigms, the analysis explores Te Whare Tangata as both a cosmological portal and political site. Using a Kaupapa Māori adaptation of reflexive thematic analysis (Braun & Clarke, 2006), five overarching themes were developed—each grounded in the lived experiences, spiritual knowing, and intergenerational wisdom of wāhine and whānau Māori. These themes illuminate Te Whare Tangata as a locus of sacred, political, and cosmological authority, surfacing kōrero of wairua, trauma, reclamation, whakapapa, and collective healing.

The analytical process followed Braun and Clarke's (2006) six-phase reflexive framework, reinterpreted through a Mana Wāhine lens foregrounds wairua, tikanga and whakapapa. Initial transcripts were subcontracted, then reviewed, corrected and manually coded by the researcher to ensure both rigour and relational accountability. Coding moved between surface (semantic) meaning and deeper (latent) cultural, spiritual, and political dimensions. Each theme was refined through cycles of reflexive engagement – guided by cultural intuition, ancestral guidance, and whakawhanaungatanga with both the kōrero and those who gifted it. See Appendix H for the Transcriber confidentiality agreement used for subcontractors.

Here, participant voices are not treated as data points but as sacred transmissions - living oracles of truth. Their words serve as evidence, instruction and cosmological insight. Each theme is introduced with contextual commentary, followed by direct quotations that center whānau voice. Subthemes are woven throughout, reflecting the layered nature of Indigenous knowledge systems. The analysis continually returns to the oranga of Te Whare Tangata – acknowledging Māori procreation as a site of political struggle, spiritual authority, and intergenerational restoration.

The pou of Mana Wāhine theory and postcolonial critique guide this chapter, offering both compass and challenge. These frameworks enable the analysis to confront colonisation's imprint on birthing systems – through legislation such as the Midwives Act 1904 and the Tohunga Suppression Act 1907, systemic racism, and clinical control - while also celebrating

the endurance and resurgence of Māori knowledge. As Pihama et al. (2002) and Gabel (2021) remind us, Kaupapa Māori rangahau must center cultural safety, relational accountability, and the spiritual dimensions of healing.

Like inspecting the tukutuku panels within a wharenui, the thematic analysis traces patterns across the kōrero. Each theme represents a section of the whāriki: the pulse of wāhine as sacred vessels, the fractures of colonial disruption, the reactivation of ancestral technologies, the weaving of sacred witnessing in midwifery, and the reclamation of wānanga as intergenerational sovereignty. Together, these themes reveal how wairua care sustains wāhine Māori as Te Whare Tangata, and how maternity systems might be transformed when grounded in tikanga, atua, and whakapapa.

Within this whare, critique and ceremony walk side by side. The kōrero of whānau is interlaced with pūrākau, atua wāhine, legislative critique, and global Indigenous perspectives. In doing so, this chapter becomes a written wānanga — a space where ceremony, testimony, and analysis converge to restore balance and strengthen Te Whāriki o Hine-te-Iwaiwa for future generations.

4.1 Te mokemoke o te wairua | Reclaiming wairuatanga in Te Whare Tangata.

This theme explores the spiritual loneliness experienced by many whānau in clinical maternity care, where disconnection from tikanga and wairua reshaped birthing experiences and eroded safety. These ruptures silenced Mana Wāhine, disrupted whakapapa, and diminished the sacredness in birth. Yet within them, emerged acts of resistance, where wāhine, whānau, and midwives worked to restore wairua as a foundation of hauora, cultural authority, and safety — not simply care, but a reclaimed birthright.

Wairua was not seen as a luxury but as foundational to hauora (Brittain et al., 2025). As Ripikoi (2015) explains, *“wairua was described as a spiritual essence, an intuitive knowing, a higher power or atua"* (p. Iv). This aligns with Mana Wāhine scholarship, where wāhine are understood as conduits linking atua, tupuna, whānau and whenua (Tomlins-Jahnke, 1996). Participants in this wānanga spoke of the impact of its absence: disconnection, a stripping away of identity, and the invisibilising of whakapapa at times of profound transformation.

“Like when the colonisers came, they already stripped the tapu-ness of wāhine… but we’re not giving up our ways of knowing this world” – wahine participant.

“[they] were making me nervous, you’ve been doing internals all day, and I'm like, no, I don’t want another internal” - wahine participant.

These kōrero illustrate the disjunct wāhine Māori feel between cultural knowing and the clinical environment. While tikanga instils reverence for Te Whare Tangata, hospital settings often lack spiritual safety, dismantling cultural grounding at moments of heightened vulnerability.

The dominance of technocratic maternity systems has deep historical roots. Davison (2020) argues that from the 1700s, midwifery's embodied and spiritual "ways of knowing" were dismissed by medical paradigms that reframed birth as a pathological process requiring surveillance and control. Whaley (2011) traces this through early modern Europe, where male-dominated medicine displaced women's authority in healing and childbirth. In Aotearoa, these ideologies were embedded through the Nurses Registration Act 1901 and the Midwives Act 1904, which centralised control and devalued traditional Māori birth attendants. The Tohunga Suppression Act 1907 further stripped spiritual authority, described by Simmonds (2011) as *"one of the most aggressive assaults on wairua knowledges"* (p. 15). The Midwives Act 1904 excluded tāpuhi, requiring training in Pākehā practices. By the mid-20th century, benefit eligibility was tied to hospital birth registration, and by 1967, 95% of Māori births occurred in hospitals — further marginalising Mana Wahine and Māori birthing practices (Simmonds, 2011, pp. 20–21). These policies embedded discourses of blame, epitomised in the Hunn Report (1961), which labelled wāhine Māori "apathetic and ignorant," narratives that persist today (Simmonds, 2011, p. 20).

Although wāhine Māori were granted the right to vote in 1893 alongside Pākehā women (New Zealand Parliament, n.d.), their tino rangatiratanga over Te Whare Tangata remained constrained. In pre-contact and early contact periods, wāhine were politically, socially, and spiritually active, often recognised as chiefs, healers, and ritual leaders (Ralston, 1993). Smith (2015) shows how colonial policies disrupted the intergenerational transmission of Te Whare Tangata knowledge, undermining wāhine Māori as spiritual custodians of birth and wellbeing. Kuia recalled their heritage as being "ignored, hidden and lost" under European influence (Smith, 2015, p. 3). The political right to vote did not restore cultural authority or maternal autonomy. Instead, colonial law continued to regulate Māori maternal bodies, rendering wāhine "invisible" in law and redefining identity through European gender norms (Gemmell, 2013, pp. 33-35).

The maternity system that emerged from this whakapapa continues to reflect a legacy of colonisation — one that alienates wairua, suppresses tikanga, and privileges clinical control over collective, ancestral knowing. Participants described these systems as spiritually barren and culturally silencing. Recognising this legacy is critical not only for understanding the present, but for reimagining maternity care grounded in wairua, whakapapa, and whānau restoration.

"During hapūtanga and ikura, the veil is thinner between the realms. So, we gotta take precautions – certain tikanga like karanga, not harvesting harakeke, taking rest, being more aware and conscious of yourself" - wahine participant.

“It’s paradigm shifting ae bro, it can instantly change your whole entire world, just from having one kōrero… you actually want to protect your hapūtanga, you wanna protect yourself and you wanna make decisions with the consciousness that you’re choosing life” – wahine participant.

These kōrero highlight how clinical settings fail to accommodate spiritual practice. In te ao Māori, birth is a sacred, whānau-centered rite of passage. When karakia and tikanga are absent, ancestral connection and wairua are silenced. This erasure is not simply personal discomfort but the removal of cultural safety, intergenerational continuity, and the tapu nature of Te Whare Tangata. These findings align with Rapua te Aronga-a-Hine, which shows mainstream maternity services often fail to accommodate Māori models centered on wairua, tikanga, and whakapapa (Tupara & Tahere, 2020), and with Indigenous literature framing spiritual safety as intrinsic to reproductive justice (Roestenburg, 2020; Simmonds, 2014).

Moreover, structural erasure of wairua is not isolated to maternity services. A systematic review of Māori health experiences reveals routine racism, marginalisation, and disconnection, with hospitals described as culturally alienating (Graham & Masters-Awatere, 2020). These findings reinforce that spiritual disconnection in clinical care is systemic.

Globally, similar critiques have emerged. In Australia, some women describe hospital birth as emotionally unsafe and over-medicalised, prompting rejection of biomedical birth for home or freebirth alternatives (Newnham et al., 2018; Jackson et al., 2020). In Canada, Indigenous doulas describe biomedical hospitals as unsafe and disempowering spaces, marked by racism, coerced interventions, and infant apprehension, leaving many families carrying grief and trauma long after birth (Doenmez et al., 2022). In Aotearoa, Abel and Kearns (1991) noted that the rise in homebirth reflected conscious resistance to institutionalisation. For wāhine Māori, such resistance carries additional weight — a spiritual imperative to restore wairua, whakapapa, and tino rangatiratanga.

These international parallels situate Māori within a wider Indigenous birthing movement — a collective effort to restore spiritual and cultural authority over childbirth. Simmonds (2014) describes this as Mana Wāhine and whenua-based sovereignty, recognising the whenua (placenta) as grounding whakapapa and bodily autonomy (Kupenga et al., 1993). This disconnection from spiritual and cultural birthing practices has not gone uncontested. Participants shared powerful acts of reclamation.

"When I gave birth to my daughter, as soon as she was out, I haemorrhaged. I was disconnected through the whole process. If I had been educated in this realm of wairuatanga, I think I would have been really hearty, but because I didn't, I was on the verge of death" - wahine participant.

"Although it was traumatic having to have a caesar as my first birth, [the Māori midwife] was awesome, and her whole āhua Māori was reassuring, I felt so safe with her that I allowed the father to go home" - kuia participant.

This moment marks a profound reclamation. One wahine participant explained: "*I didn't get that wairua-safe care… one of them was Māori, but again, she wasn't… just very generic. Nothing to it, ticking boxes, not creating like safe spaces for me, and also not being very aware of the type of kupu that they use… [that wasn't mana enhancing when describing her frustration at my pēpi being postdates]".*

Another wahine participant echoed: *"My last two births, all I got different was kawakawa panipani but nothing else touched on the wairuatanga [of Te Whare Tangata]..."*

These testimonies highlight colonisation's impact on Māori midwifery, where practice has sometimes become tokenistic. Yet they also show the potential for reclamation. When midwives embody Kaupapa Māori and whakapapa connections, whānau feel spiritually safe and recognised. In these spaces, participants described moments of realisation — spiritual recognitions that shifted consciousness and opened pathways for wairua-led healing. One participant noted that she learnt far more from a Māori midwife with whom she shared close whakapapa ties, who brought depth and clarity to the wairuatanga of Te Whare Tangata. Such moments show Kaupapa Māori midwifery as reclamation and education — restoring spiritual safety, empowering wāhine, and reconnecting whānau with atua and tupuna.

These quotes capture the immediate restoration of sacred presence when a midwife aligned with Kaupapa Māori practices held space for both clinical and spiritual needs. Their experiences reinforce that culturally safe midwifery care is not merely a preference, but a pathway to healing and reconnection. Wairua was described not as abstract, but as a vital force in birthing safety — a reconnection to whenua, tupuna, atua, and self. Spiritually guided birthing thus becomes a portal of reclamation, where intergenerational trauma is transmuted and ancestral threads rewoven. This reweaving occurs within Te Whare Tangata — the sacred house of humanity — where the physical and metaphysical converge (Pere, 2005; Mikaere, 2017). As Pere (2005) describes, the womb is not only a site of reproduction but cosmological gateway — holding within it the memory of iho, the phases of the maramataka, and the microbiome codes of whakapapa. In this space, wāhine are not passive recipients of care, but

active vessels of mana atua, mana tupuna, and mana motuhake (Gabel, 2013; Simmonds, 2011).

As Pihama et al. (2019) affirm, *"the body of the wāhine Māori is not simply biological — it is spiritual, political, and cosmological. Te Whare Tangata is a site of sacred power where whakapapa enters the world"* (p. 31). Reclaiming the womb, then, is not only a reclamation of birthing practices, but sovereignty over the narratives of how and where life begins. *"Hine-te-Iwaiwa is often referred to as the atua of childbirth, weaving, and the moon, but her role extends far beyond these responsibilities. She is central to the understandings of wāhine as carriers of knowledge, holders of space, and guardians of intergenerational wellbeing"* (p. 24). In this way, Hine-te-Iwaiwa stands as the guardian of ceremony, space, and sacred continuation — honoured whenever midwives invoke atua, tūpuna, and karakia into their practice.

These kōrero reveal that when wairua is absent, birthing becomes spiritually barren and disempowering, with impacts that reverberate across whakapapa and generations. Yet in its reclamation, Te Whare Tangata is restored as a sacred site of cosmological, political, and intergenerational continuity. From here, the focus turns to collective remembrance — how whakapapa, wānanga, and atua relationships reweave the spiritual fabric of birthing.

4.2 Te iho o te ao | The sacred pulse of wāhine.

This theme explores te iho o te ao — the sacred pulse carried within wāhine Māori. Participants described their bodies not in clinical or biomedical terms, but as sacred vessels and cosmological portals through which whakapapa, atua, and ancestral memory flow. In their kōrero, Te Whare Tangata was honoured as a site of spiritual authority and sovereignty, where birthing was understood not merely as physical, but as metaphysical, cultural, and political. As Gabel (2013), Mikaere (2011), and Simmonds (2011) confirm, wāhine embody continuity between realms; participants echoed this truth. One wahine participant expressed it simply: *"Our bodies are tapu and we don't like to allow anyone to touch them or see them."*

Others reflected on embodied practices that affirmed this tapu. One wahine participant recalled: *"No one taught me how to do it… when my baby was born and I was able to go home and be in my own space, at nighttime, I took my baby out and mihi my baby to the cosmos."*

A kuia participant affirmed the continuity of such tikanga: *"That's also a tribal thing, that's what my tane does, that's what his mother did, and what her mother did before her. They hold them [pēpi] out to the four winds… If you go into a meeting house or somewhere strange, and the baby won't settle… they pulled the baby up outside to the moon and then face it to the four winds and it settles. That's a tikanga from my Te Arawa partner."*

These testimonies position the newborn not only in relation to their mother, but in relation to the wider cosmos — Papatūānuku, Ranginui, the winds, and the moon — affirming belonging and balance. They illustrate how wāhine reclaim bodily autonomy not as an individual act, but as a sacred obligation to past and future whakapapa, affirming their role as ancestral vessels.

Yet this sense of sacred embodiment has been disrupted by histories of colonisation, medical trauma, and the imposition of shame. As one wahine participant admitted: *"I didn't trust my body. I kept thinking something was going to go wrong".*

Fear of the body was frequently tied to clinical encounters that disregarded wairua and cultural safety. This aligns with what Mikaere (2022) describes of colonisers imposing shame on the reproductive roles of wāhine Māori, disregarding the power and tapu of *Te Whare Tangata*. The imposition of Western medical frameworks — and the deliberate criminalisation of Māori healing through legislation such as the Tohunga Suppression Act 1907 — actively dismantled wāhine Māori's autonomy, spiritual practices, and embodied knowledge systems.

Participants also spoke about the cosmological nature of whakapapa inheritance carried through DNA, where tupuna re-emerge through mokopuna: A wahine participant described: *"[when the pēpi] enters Te Whare Tangata it already has this certain vibration and essence... between the two parents, it's ancestors that already sit within the DNA structures of us, they come and start to weave around this energy... whatever lives that they have lived here are at a certain tone and this particular mokopuna is resonating with these tupuna... they come together as a collective".*

Another wahine participant added: *"that make this mokopuna.... when the baby's born and you think, jeez you didn't look like any of your parents... but the body knows that this was like a tupuna that lived a hundred years ago".* A kuia participant summarised this succintly: *"Hence the throwbacks".*

A tane participant further elaborated: *"Our tipuna are behind the scenes, weaving that baby to become that baby... just that mental picture of our tipuna doing that, you know, it's just a beautiful way to see it like that".*

These reflections align with epigenetic rangahau on intergenerational transmission of memory and trauma. For participants this was not theory but lived ancestral truth. Valdez (2025) shows how racialised birth trauma imprints across generations through biological and social pathways, while Lehrner and Yehuda (2018) demonstrate that cultural trauma can alter gene expression and family practices, carrying both vulnerability and resilience forward. Warbrick et al., (2023) likewise highlights how Indigenous systems such as the maramataka embed intergenerational rhythms of health and inheritance, reaffirming whakapapa as both

knowledge framework and lived biology. In this light, Heke's (2023) call to reclaim embodied wisdom as a whakapapa estate confirms that healing requires reconnecting with ancestral memory alongside structural change.

Colonial interventions further disrupted this inheritance. Mark and Koea (2021) document how rongoā and birthing knowledge were delegitimised within mainstream health systems, while Gabel (2021) and Mikaere (2011) show how this dislocation fractured intergenerational wellbeing — echoes still visible today in maternal inequities and the spiritual estrangement many wāhine experience in clinical care. Against this backdrop of disrupted transmission, participants described wānanga as a site of restoration — spaces where ancestral knowledge was reawakened, shifting how they understood their bodies, whakapapa, and the sacred responsibilities of birth.

"It's paradigm shifting, it can change your whole entire world, just from having one kōrero… you actually want to protect your hapūtanga, yourself and make decisions… that are intentional and you're choosing life" – wahine participant.

Another wahine participant reflected: *"If I had known about these things [wairuatanga of Te Whare Tangata] before becoming a mother, I would have been a better mother, knowing how to look after myself, mentally and emotionally… if someone had told me in a setting like this [wānanga], I would have walked out of those doors thinking, holy shit – I'm magical, wow, I'm actually really quite powerful, I can be a game changer… it's giving power and mana back to young wāhine, if I had this knowledge back then, I could have treated myself with so much more dignity than I did".*

"Wānanga like this… it's offering more spaces of reconnection with self, for tāne, and wāhine in general, which then opens more organic opportunities [to be present here]" – tane participant.

Wānanga emerged in this rangahau not simply as sites of knowledge exchange, but as spaces of transformation. Participants described how kōrero shifted their sense of self, reframed their birthing journeys, and re-ignited confidence in the sacredness of their bodies. For wāhine, these moments opened pathways to reclaim mana and dignity long eroded by colonisation; for tāne, they offered opportunities to stand in support of whakapapa as spiritual as well as physical continuity. The impact of wānanga, then, was not only educational but restorative — a collective re-centring of wairua that reshaped how whānau approached hapūtanga and birth.

One tane participant reflected on whakapapa as divine coding: *"Kauae runga, kauae raro – as above, so below, the DNA is meant to be a physical representation of the codes from wairua, of all existence."*

Another tane participant added: *"If our wāhine have a little bit of this [wānanga] it'll be like comforting for me to know that they know how actually a powerful transaction this time is…".*

Together these voices affirm that reclaiming wairuatanga in birth is both a personal and political act — restoring Mana Wāhine and resisting the reduction of birth to clinical process. Participants also reflected on the demands of modern life that undermine wairua-led birthing.

"In today's day, most people like go to work when they're hapū, like right up until sometimes the day before they have the pēpi. That should be a time of deep rest… it's such a normal part of society too — you wouldn't even comprehend taking extra maternity leave… and we are so used to it now, we've gone away from how we used to live. Even when wāhine had their ikura, they didn't have tasks to do. Everyone wrapped around them, you know, helped. Yeah, it's totally different [now]" – wahine participant.

"I think it's just that we are always kept busy, every day we feel like we gotta do this and gotta do this. This tinana can't… the nervous system is like the physical representation of wairua… which is in survival mode" – tane participant.

These reflections show how structural pressures fracture rest, ritual, and wairua — yet also how wānanga provides counter-spaces of reconnection.

Kōrero about the whenua and ikura revealed potent acts of reclamation of sacred birthing rites. The whenua is not merely a biological byproduct — it is a spiritual vessel, and its return to Papatūānuku anchors the child within a cosmological and ancestral continuum.

"We practice it [traditional mātauranga around whakawhānau] the minute we return the placenta [to the earth], that's where the impact is, and we must continue to teach on to the next generation, so they can continue to practice right down to the pito [being buried]." – kuia participant.

"They don't teach about the placenta and the importance of taking that with you. A lot of girls have their babies and the placenta's are there [left at the maternity unit] and they don't even go back to collect it" – kuia participant.

"Waikato was like that; me and baby were taken away and the father waits for it. I said – make sure that you say we want our whenua. So luckily, they had that provision in Waikato to wait for the whenua, he waited for the whenua twice [with both pēpi]" – kuia participant.

"I raced back to Gisborne to collect my mokopuna's whenua and lucky, still in the fridge, because they were going to discard it. It's quite insensitive really" – kuia participant.

As Papa Anaru explains, *"The placenta is the place of being and belonging. That is the place of all things. That is the vessel from the ancestors"* (as cited in Robinson, 2014, p. 210). Kupenga et al. (1993) likewise affirm that *whenua* binds child, mother, and land in continuity. As Te Awekotuku (1991) reminds us, "As the land remains, so do the people, who reflect its health, prosperity and creative vigour" (p. 68). These beliefs continue to influence the health and identity of generations born in resistance to colonised birthing systems, asserting that affirming the sacred body is foundational to restoring Mana Wāhine. As Gabel (2021) outlines in He Pā Harakeke, reclaiming embodied wellbeing is central to Māori whānau ora.

Despite systemic failings, some shifts toward cultural recognition have occurred. The growing acceptance of traditional placental practices, such as returning the whenua to Papatūānuku, signals a belated acknowledgement of mātauranga Māori within clinical systems. Policy changes like the Human Tissue Act 2008, now supported by hospital practice (Wepa, 2015), illustrate that bicultural reform is possible — yet remain piecemeal without sustained transformation. For wāhine Māori, this is not symbolic but a reclamation of tino rangatiratanga over Te Whare Tangata and the spiritual journey of new life in its entirety. It marks a shift away from the pathology of pregnancy toward the restoration of sacred birthing rites that recognise the full cosmology of whakapapa.

This understanding of the body as tapu is also affirmed in the Mana Wāhine Kaupapa Inquiry, where evidence recorded that *"through Te Whare Tangata, wāhine bridged life and death, connected humanity to the atua and whenua"* (Waitangi Tribunal, 2023a, p. 7). Menstruation, pregnancy, and birth were understood as sacred thresholds — spiritually significant stages safeguarded through tikanga and the observance of tapu, upholding wāhine as bearers of whakapapa and custodians of continuity.

Participants also emphasised menstruation as a sacred threshold. *"[Regarding ikura] that kind of conversation should really be held by your kaitiaki and brought to you to help you to understand that it's a beautiful part of life, and what it means is that your tinana is getting ready to make space available and ready to create"* – wahine participant.

A kuia participant remembered her own experience: *"When I first got my ikura, my father put a hangi down. He obviously understood the importance, the tikanga… he was a hangi guy, there was a big gathering of whānau. I was embarrassed."*

These teachings affirm ikura, hapūtanga, and birth as spiritually significant life stages safeguarded through tikanga and tapu observance. Te aho o te ao — the sacred pulse of

wāhine — is carried in Te Whare Tangata as a site of cosmological remembrance and intergenerational continuity. Participants affirmed that reclaiming these knowing's is not symbolic, but essential to whānau oranga and tino rangatiratanga. This reclamation of conscious awareness also revealed the tensions wāhine face in maternity care, where structural systems often fail to uphold the sacredness of Te Whare Tangata. It is here that whānau voices turn to the impacts of fear, disconnection, and the embodied legacies carried across births.

"Fear only exists because of lack of connection with wairua" - tāne participant.

"I was separated from my pēpi for the first six to seven hours of her life [due to complications] and she sat with my sisters, and in that process they decided that they would name her... taking away that experience from me... that fear from that birth... I always held that fear when I came to birthing my next child too" - wahine participant.

And a tane participant added: *"And physically you've brought in fear, it creates tensions – and I can only imagine what that does when you're trying to give birth".*

"your body doesn't relax and it causes those injuries" - wahine participant.

"if I didn't come with that fear [of being disconnected from my body and receiving a birth injury previously], or if I was educated in this wānanga realm, I think I would have just been really hearty, but because I didn't, it like instilled fear in me, and I carried that through to my next birth, and that's when I had complications again..." - wahine participant.

Participants also spoke to the disconnection created by colonisation and the structural health system. A wahine participant explained: *"Yet… the disconnection through colonisation is so real, we don't really think about those dimensions… and so many women go through a Pākehā system and your birthing experience… you're not gonna get asked how are you looking after your mental wellbeing, or your wairua".*

Although frameworks such as the Pae Ora Act (2022), UNDRIP (2007), PMMRC (2024), and WAI 2575 affirm the rights of wāhine Māori to culturally grounded and spiritually safe maternity care, whānau kōrero confirm these rights remain far from realised.

As one tane participant reflected on structural dehumanisation: *"We just gotta realise that the system aye, is not designed for human beings, it's designed for robots".*

Together, these voices illuminate the systemic failure to deliver Indigenous reproductive justice — the right to birth with cultural integrity, autonomy, and access to traditional practices (Gurr, 2014; Simmonds, 2011; United Nations, 2007). Reclaiming the sacredness of wāhine bodies is not simply about birthing differently but an act of mana motuhake — disrupting colonisation

at cellular, spiritual, and structural levels, and remembering that the womb is the original threshold where genealogies and futures are carried (Gabel, 2021; Mikaere, 2011). Yet this vision remains under threat as Aotearoa's health system faces austerity cuts, underfunding of Kaupapa Māori services, staff burnout, and deregulatory proposals (Green, 2025). Stripped of relational care, cultural safety, and resourced midwifery, whānau wellbeing is placed at risk, undermining both Mana wāhine and the futures birthed from Te Whare Tangata. Despite equity commitments such as the Pae Ora Act (2022), maternal health inequities for wāhine Māori remain acute (PMMRC, 2024; Waitangi Tribunal, 2019).

A kuia participant linked this to the wider political economy: *"Under-investing in the health system and all of the systems actually, so they can collapse and privatise them, that's the bigger picture. That's what's happening with the politics at the moment".* Further adding: "[Setting up health clinics] they're collecting the money, but they haven't got our best interests at heart".

A wahine participant described the superficiality of some maternity care: *"It's just hello, how are you? Let's hear the heartbeat and write down a few things and we'll book you in for your next one… the mokopuna that are coming through… we're living through lots of disconnection".*

Another reflected on spiritual silencing: *"Anything wairuatanga that you speak about that doesn't sit under like a Christian lens… that type of kōrero is just disregarded with – what are you talking about?… that sounds so pōrangi, so then you get whakamā to even like speaking of those things"* – wahine participant.

And another wahine participant affirmed reconnection: *" I was told these things weren't real; our gods aren't real, but they are – you know, we see them everywhere... you know, they're all our elements ae... reconnecting with you know, things like matakite and trusting our instincts and gut feelings, ae that's wairuatanga".*

Ultimately, te iho o te ao — the sacred pulse of wāhine — beats within Te Whare Tangata as a site of cosmological remembrance and intergenerational continuity. Reclaiming these knowings is not symbolic but essential to whānau oranga and tino rangatiratanga. Honoured, they safeguard intergenerational wellbeing; denied, they leave fear and disconnection to take root.

4.3 Te ara whakaora o Te Whare Tangata | Reclaiming the lineage.

This theme turns from rupture to reclamation, showing how whānau and midwives re-activate ancestral technologies of care to heal disconnection and restore the mana of Te Whare Tangata. Te ara whakaora — the pathway of healing — reveals birth as a cosmological

threshold, a sacred moment where whakapapa, atua, and intergenerational memory converge. Building on the previous theme of spiritual disconnection, the focus here is on acts of reclamation: kōrero that restore Te Whare Tangata as a site of spiritual healing, ancestral reconnection, and whakapapa sovereignty. In these accounts, birth is no longer a clinical event but a spiritual rite, repositioning wāhine Māori as sacred custodians of intergenerational oranga.

The kōrero reveals a dual current: ancestral activation and historical disruption. From these stories emerges a wero — to repatriate ourselves to matriarchal wisdom suppressed through colonisation, and to reclaim whakapapa sovereignty in systems, in wānanga, and in birth. For iwi such as Ngati Porou, this reclamation carries both spiritual and strategic weight — offering a pathway to restore Te Whare Tangata as a site of healing, education, and cosmological leadership. Participants described Te Whare Tangata not as anatomy alone, but as a cosmological threshold where wairua becomes tinana and tūpuna guide the becoming of mokopuna.

One tane participant reflected: *"When you asked what does wairuatanga mean in relation to Te Whare Tangata, I just looked at it as the portal to other dimensions that bring life into this reality, turning wairua into tinana – the physical. And what's more sacred than that? So yeah, it's that knowledge that's very valuable and missing"*.

Another wahine participant offered the metaphor of whenua as soil: *"We're the soil, we're the mother, so whatever we're thinking secretly or openly, what we're feeling, it's already imprinting energetically on our pēpi. So like, there's so many dimensions of that — our relationship at the time of our hapūtanga with our tāne, what he's doing, how he's creating stability, protection… when we're carrying a pēpi"*.

Here, the mother is not a passive vessel but an active environment, shaping the consciousness of her pēpi through emotional, relational, and spiritual dimensions. This understanding restores the mana of wāhine as the first landscape each pēpi inhabits. Wānanga kōrero also illuminated how trauma and disconnection imprint across whakapapa when wairua is absent.

One wahine participant recalled: *"disconnection starts with yourself and your pēpi feels that. It's not just the physical connection that every pēpi inside attached to you, they feel your emotions as well… they're literally a part of you and feel what you feel too"*.

A tane participant added: *"It's a traumatising generation ae… so that's a bad start for our babies"*.

A kuia participant pointed out how small acts of grounding could protect against future disconnection: *"It's really important because not only does it give their child a sense of belonging, it also solidified things later on… many of our kids are disconnected… if that same child had that same grounding process, you'd find it wouldn't go wrong and do that whakamomori".*

These reflections align with Indigenous knowledge recognising that what is carried in the womb is not only physical, but also emotional, generational, and cosmological (Mikaere, 2011; Pihama et al., 2014). Participants spoke powerfully about how clinical encounters can either disrupt or uphold the sacredness of Te Whare Tangata. Many described hospital practices that created disconnection by overriding wairua-led ways of knowing.

One wahine participant highlighted the need for relational continuity after birth: *"Understanding the importance of skin-to-skin, so allowing mama like time with baby before they take the baby to do all the checks"*.

For another whānau, this was denied. A tane participant remembered his sister's labour: *"I was at my sister's birth and they took the baby straight away… sometimes it's important, but they're taking their baby without giving it straight to mum. My sister was going – where's my baby? Give me my baby! So, there's already that little bit of fear and stress they've incorporated in the situation".*

A kuia participant described the sense of exposure: *"You don't feel supported [by health professionals] when you most need support, makes you feel vulnerable"*.

Yet others recalled when connection was upheld through culturally safe, relational care. One wahine participant reflected on her caesarean birth: *"I have had four caesareans and only one of the obstetricians actually talked to me, and that was my best birth… she talked to me and my partner the whole time and explained what she was doing, that connection rather than being just a patient"*.

These accounts expose the ongoing imprint of colonial maternity systems that privilege efficiency, surveillance, and clinical authority over tikanga, wairua, and whakapapa. The result is not simply procedural discomfort but a rupture in the continuity of maternal and intergenerational wellbeing.

Another tane participant emphasised the role of wairua in countering fear: *"Fear only exists because of lack of connection with wairua... you can still have some fear, don't get me wrong, but it's greatly magnified when you think you're just a physical being that could die from anything at any moment, and that's all there is to it***".**

Together these accounts reveal that birth spaces are never neutral. They can either reproduce colonial disconnection or become sites of spiritual repair. These were not abstract ideals but embodied practices, woven into daily life, hapūtanga, and whānau traditions.

One wahine described growing hue alongside her pēpi: *"In my last pregnancy, I started my journey at Eastern Institute of Technology, and I wish I had started growing hue. There's one that takes nine months aye, you can grow it alongside your pēpi and then use it as your taonga pūoro for the oro — the vibrations to help in childbirth"*. Growing a taonga in parallel with a pregnancy affirms whakapapa as a living resonance, where sound, vibration, and birth become cosmologically aligned.

A tane participant spoke about the koau, a traditional flute: *"I was taught the koau… there's certain notes that straighten everything in our DNA system, our whole structural system, our biology, into its right place. A lot of babies are coming into this world scattered"*.

Here, music is not entertainment but a healing frequency, rebalancing whakapapa as pēpi crosses thresholds of becoming. These accounts show that healing Te Whare Tangata requires more than critique of colonial disruption; it requires re-activation ancestral technologies of care. When wāhine and whānau engage in practices like planting hue, playing taonga pūoro, or reciting oriori, they are not only supporting the birth of a child — they are reweaving the continuity of whakapapa. This is reclamation as lived sovereignty, restoring Te Whare Tangata as both cosmological and political space.

This movement of reclamation extends beyond Aotearoa. Across colonised nations, Indigenous-led birthing initiatives are reweaving cultural safety, sovereignty, and resilience into maternal health. In Canada, the revival of Inuit midwifery in Nunavik has reduced maternal evacuation and restored community trust (Pandey, 2023). In the United States, Native midwives are integrating ancestral practices — birthing songs, rope techniques, traditional pregnancy toolkits — to restore spiritual connection and autonomy (Tribal Health, 2024; The Circle News, 2023). These examples affirm that Māori are part of a wider Indigenous resurgence in birthing sovereignty.

Yet despite Crown obligations under Pae Ora (2022), repeated findings from PMMRC (2024) and WAI 2575 (Waitangi Tribunal, 2019), maternal health inequities for wāhine Māori remain stark. Mortality rates are more than double those of non-Māori, with suicide the leading cause of maternal death — evidence of systemic neglect and ongoing breaches of Te Tiriti. Policy shifts such as ACC's cover for rongoā Māori in maternal birth injuries represent progress (ACC, 2025a, 2025b), but systemic barriers persist. Māori midwives still lack a dedicated Māori midwifery curriculum, and Kaupapa Māori services remain chronically underfunded (Tupara & Tahere, 2023; Midwifery Council of New Zealand, 2021).

To restore Te Whare Tangata is to restore the horizon line of our people — where whakapapa, atua, and knowledge rise with the dawn. This is not simply a matter of clinical safety or cultural preference; it is a spiritual imperative. Healing requires the reweaving of cords between realms, so rupture transforms through wairua, tikanga, and collective intention. Papa Anaru reminds us this work must be spiritually aligned and decisive: like light through fibre optics, healing must travel swiftly through karakia, kōrero, touch, and aroha (Te Waka Huia, 2015). We plant this mātauranga deep within Hine-te-Iwaiwa, anchoring it in te kore, so it may rise again into te ao mārama — through ceremony, education, wānanga, and the rhythms of the maramataka, guided by Hine-te-Iwaiwa.

This is further affirmed through pūrākau. Hine-tītama, the first human form to be created, was born before man — she is the tuakana, carrying the sacred responsibility of caring for teina (Te Ara, n.d.). Her descent into rarohenga, becoming Hine-nui-te-pō, reflects the profound role of wāhine as kaitiaki of thresholds — guardians of both entry and exit, of life and death, of realms seen and unseen (Pearse-Otene, 2021; Te Ara, n.d.). Her story reminds us that Mana wāhine is not a modern intervention but an ancestral principle embedded in the architecture of Te Whare Tangata (Pearse-Otene, 2021; Perris, 2018).

These accounts illustrate that restoring wairua to birth is also reclaiming sovereignty. Healing is not only personal but constitutional and intergenerational, reweaving sacred threads colonisation sought to sever. In reclaiming these narratives, balance is restored — not to dominate, but to realign. This kaupapa revitalises Māori birthing knowledge and reminds institutions that clinical safety is incomplete without spiritual and cultural safety. Reclaiming Te Whare Tangata is therefore not symbolic but structural, and essential for the collective hauora of future generations. From this realignment we move into Te Whare Pora o Hine-te-Iwaiwa- the sacred house of weaving, where midwives stand as kaitiaki, sacred witnesses who bring ceremony, protection, and whakapapa into the birthing space.

4.4 Te Whare Pora o Hine-te-Iwaiwa | Weaving sacred witnessing in Midwifery.

Within Te Whare Pora, midwives emerge not merely as clinicians but as spiritual custodians - witness of thresholds, weaving safety and sovereignty through wairua-centred care. Having restored balance through the reclamation of whakapapa narratives, we now return to Te Whare Pora o Hine-te-Iwaiwa where birth is understood not simply as event but as ceremony, and midwifery as the embodied practice of weaving; people, place and spirit into being.

Hine-te-Iwaiwa, whose presence has guided this rangahau from its inception, stands here as both atua and ancestor — the embodiment of sacred balance between creation, learning, and protection. As Pere (2005) explains, newborn girls were once dedicated to Hine-te-Iwaiwa through karakia, affirming wāhine as life-bringers and custodians of sacred thresholds. Te

Whare Pora is her classroom: a space where knowledge and spirit converge, teaching that learning flows continuously through ritual, practice, and daily life. Like the rhythms of water — sea, rain, spring — mātauranga circulates through wāhine, procreation, and whānau, sustaining balance and continuity. Heke (2023) affirms this dual role: Hine-te-Iwaiwa as both the gentle hand that guides birth and the strategic mind that safeguards Indigenous wahinetanga. In this theme, the resurgence of atua wāhine wisdom and the reclamation of midwifery as sacred service are honoured, showing how wairua-led practice protects whānau sovereignty and restores the mana of Te Whare Tangata.

In this context, Māori midwives are not simply clinicians. They are tohunga-like presences — invoking karakia, anchoring mauri, and restoring the spiritual integrity of Te Whare Tangata. Their role embodies the legacy of Hine-te-Iwaiwa: midwifery as a practice of Mana wāhine and spiritual sovereignty. As one kuia participant reflected:

"Although it was traumatic having to have a caesar as my first birth, [the Māori midwife] was awesome, and her whole āhua Māori was reassuring, I felt so safe with her that I allowed the father to go home".

Her words highlight that safety in birth is not only measured by clinical outcome but by the presence of wairua and āhua Māori. Even in a highly medicalised context, the midwife's cultural presence shifted the environment from vulnerability to trust. Another wahine participant described what this knowledge could have meant for her:

"If I had known about these things [wairuatanga of Te Whare Tangata] before becoming a mother, I would have been a better mother… it's giving power and mana back to young wāhine".

Here, wairuatanga is framed as transformative knowledge — not a peripheral add-on, but a foundation for dignity, agency, and whakapapa continuity. Her kōrero reminds us that the absence of such practices is not neutral: it is a breach that diminishes mana. Taken together, these accounts affirm that practices such as karakia and ritual are not ornamental. They are metaphysical boundary-work — setting the terms of safety, activating ancestral presence, and reconnecting birth to whakapapa and atua. In doing so, Māori midwives re-enter Te Whare Pora as spiritual kaitiaki, making the invisible visible and the sacred tangible. A wahine participant further explained:

"you know that energy cannot be created and it cannot die, and so like when it starts to take new form right and enters Te Whare Tangata, it already has this certain vibration and essence… even within the womb, between the two parents, it's like the ancestors that already sit within the DNA structures of us, they come and start to weave around this energy".

Despite these systemic pressures, Māori midwives reclaim their ancestral roles — using pepeha to anchor māmā, incorporating mirimiri and karakia to align body and spirit, and facilitating birth as a spiritual retrieval event. Through taonga pūoro, essential oils, waiata, karakia, and sensory environments, midwives co-create spaces attuned to wairua. These practices facilitate shifts into alpha/theta states — increasing oxytocin, reducing pain, and activating hormonal flow in labour (Simavli et al., 2014; Chehreh et al., 2023).

As one wahine participant reflected: *"I was doing like, mirimiri, things like that to try and soothe me as well".* Her kōrero emerged in a wider discussion about how these practices were absent in clinical environments, leaving whānau to self-manage. As a tane participant explained, *"Those parts, those vital parts aren't taught to them [whānau and midwives]".* A participating kuia added, *"You don't feel supported when you most need support, makes you feel vulnerable,"* and another wahine participant echoed, *"Really vulnerable".*

These voices reveal how the absence of wairua-led care is experienced as vulnerability, not safety. For whānau, spiritual practices such as mirimiri or karakia are not complementary extras but essential supports; without them, the burden shifts back onto māmā and whānau to create grounding in moments of profound intensity.

Yet such practices remain excluded from clinical training — siloed as "alternative therapies" despite their cultural and therapeutic value (NZCOM, 2018). Midwives now navigate a fractured landscape of unit closures, burnout, hospital overreach and spiritual suppression (Dixon et al., 2017; Suleiman-Martos et al., 2020). The profession faces collapse, not only from staffing shortages, but from disconnection of wairua and cultural grounding.

Encouragingly, the Kahu Taurima programme began reintegrating rongoā Māori into maternity care, funding partners to provide mirimiri, whitiwhiti kōrero and romiromi for hapū māmā (Health NZ, 2024). Yet restructuring has disestablished key roles, creating uncertainty and capacity loss (Thomas, 2025). These initiatives remain vulnerable to systemic instability.

Despite Māori comprising a significant and growing portion of the birthing population, the midwifery workforce remains overwhelmingly non-Māori. By 2038, Māori will make up one-third of the child population (Te Puni Kōkiri, 2017), and wāhine Māori already represent approximately one-quarter of annual births. Yet, the 2023 Midwifery Workforce Survey recorded only 237 midwives who primarily identify as Māori — just 8.3% of the total workforce, rising to 12.9% when including those with Māori as a secondary or teritary ethnicity (Midwifery Council of New Zealand, 2023). This imbalance signals a crisis of cultural representation and a critical equity gap in maternity care. Without urgent structural change, Māori whānau will continue to birth within systems that do not reflect or uphold their values, tikanga, or spiritual needs.

“I’ve had 4 pregnancies, 4 different midwifery services, 3 Māori and 1 Pākēha. What’s really important when promoting being a Māori midwife is actually being completely Te Ao Māori, not just having a Māori name and still being the exact same as a Pakeha one,” - wahine participant.

*"I didn’t feel safe birthing my last pēpi, even though they were Māori Midwives, I was very aware of the kupu they used to describe how my pēpi was a little sh*t for not coming, and that really f***ed me off, because I just thought... that’s a baby.. And you’re just money to them... [I literally left and drove five hours to birth with my tuakana, at 41 weeks hapū]”* - wahine participant.

As Tupara and Tahere (2020) affirm, Māori midwives bring irreplaceable expertise — not only in clinical care but as spiritual kaitiaki of the birth space. Their practice is embedded in whakapapa, karakia, wairua, and ancestral presence. Yet, this form of care remains marginalised by a health system that privileges biomedical authority and technocratic models of birth. As Fahy (1998, p11) cautions, “as a profession, we need to be more conscious of the way in which our discipline has been subsumed into a techno-rationale science, away from our ‘with woman’ focus”. Whānau affirmed that safety in birth is not defined by procedures alone, but by the cultural and spiritual presence of those who hold the space.

As one kuia participant explained: *“number one they [health professionals] have to make you feel safe - [that] you’re going to bring your baby into this world safely”.*

Her words resonate with the lived experience of many participants, who emphasised that wairua-led midwifery is not an adjunct to practice but the foundation of maternal wellbeing.

This kaupapa demands more than representational inclusion; it calls for the reclamation of sacred practice—anchored in Mana wāhine and carried intentionally into policy, education, and daily midwifery praxis.

I carry this truth personally. The spiritual glissando — a resonant echo of transformation — imprinted itself on me after returning to Aotearoa from Indigenous knowledge exchanges with Native American midwives and elders in Toronto, Canada. In the sacred liminal space of the following the birth of my fourth child, I relocated my whānau to Tairāwhiti. This move was both personal and political: a conscious reversal of the urban drift that had disrupted my whakapapa, and a commitment to re-indigenising my practice in service to local whānau.

Building on the early successes of Nāti Pēpi in enhancing whānau-centred, Kaupapa Māori maternity care across the East Coast, inter-regional collaboration through the conceptualisation of Kahu Taurima secured funding and transitioned the initiative from pilot to

iwi-led service under Ngati Porou Oranga. This strengthened the integration of clinical and cultural practice across the rohe and advanced the iwi's vision for a functional primary birthing space on ancestral land. While philanthropic funding for the birthing unit had been secured earlier, the inclusion of Nāti Pēpi within Ngati Porou Oranga provided the governance, clinical infrastructure, and mātauranga framework necessary to realise this kaupapa.This model is not theoretical; it is living proof that when Māori midwifery leadership is resourced, supported, and trusted, cultural safety, clinical excellence, and spiritual sovereignty can co-exist.

Yet not all iwi have access to such spaces. This remains a stark equity issue rooted in colonisation and the systemic erosion of Māori birthing sovereignty. The Nāti Pēpi model of care offers a blueprint — showing what becomes possible when whānau, hapū, and iwi mobilise tino rangatiratanga over Te Whare Tangata. Participants reminded us that birth is always more than a physical event; it is an intergenerational transmission of wairua. As one wāhine participant reflected: *"Disconnection starts with yourself and your pēpi feels that, it's not just the physical connection that every pēpi inside attached to you, they feel your emotions as well… they're literally a part of you and feel what you feel too"*.

A kuia participant emphasised that the whenua itself holds this continuity: *"We practice it [traditional mātauranga around whakawhānau] the minute we return the placenta, that's where the impact is, and we must continue to teach on to the next generation, so they can continue to practice right down to the pito [being buried]"*.

The restoration of birth to whenua is not merely geographical — it is cosmological. It realigns birthing with atua, whakapapa, and the spiritual infrastructure of our people. This is the beating heart of Te Whare Pora o Hine-te-Iwaiwa, where midwives are not only clinicians, but weavers of sacred thresholds - protectors of life carrying the memory and grace of our ancestors. These narratives affirm that equity in maternity care cannot rest on clinical competence alone; it requires wairua-led midwifery that restores Mana wāhine and honours Te Whare Tangata as a site of sovereignty.

4.5 Whare wānanga ki tōna Marae | Reclaiming intergenerational knowledge, strength and sovereignty.

The marae emerges here as a living whare wānanga — a collective site where ancestral knowledge, spiritual safety, and tino rangatiratanga are reawakened in practice. If Te Whare Pora is the cosmological house of weaving, the marae is its living embodiment — a whare wānanga where ancestral memory is activated in collective practice. From the intimate threads of midwifery, we now step into the wider whāriki of whānau, hapū, and iwi. Here, the weaving of knowledge gains its fullest strength, sustained by collective voices and intergenerational

presence, showing how wairua-led learning spaces restore both wellbeing and authority over Te Whare Tangata.

For participants, wānanga held on their own marae were far more than a rangahau method. They were sacred sites of reclamation, healing, and transformation. Whānau spoke of feeling spiritually safe, seen, and connected in ways they had never experienced in clinical maternity spaces. The collective nature of the kōrero activated intergenerational remembering, cultural affirmation, and the reclamation of embodied knowledge (Smith, 2021; Pihama et al., 2014).

"It's a powerful moment in the wairua… you can feel it. There's this moment in the wairua side of it that's more powerful than what is happening on the physical side" — tane participant.

"When the sperm enters the egg, there's like a flash of light… and to me that's wairua entering the physical" — tane participant.

Such kōrero reflect what Tupara and Tahere (2020) describe as the vital role of culturally sustaining, Māori-led midwifery education and support structures. Wānanga on the marae enable spiritual and bodily sovereignty, affirm whakapapa continuity, and create intergenerational safety. As Pihama et al. (2014) remind us, wānanga are not simply pedagogical tools but spiritually anchored spaces of identity, healing, and resistance.

This theme honours wānanga as transformative methodology grounded in mātauranga Māori. Smith (2021) insists that Indigenous rangahau must emerge from the lived realities, aspirations, and resistance of Indigenous peoples. On the marae, wānanga move beyond observation, positioning the researcher as participant, witness, and vessel for ancestral transmission (Pihama et al., 2014). Wānanga are therefore not just cultural practices, but political and spiritual acts of reclamation and renewal (Brittain et al., 2025; Paringatai & Wharerau, 2021). As Hana-Rawhiti's haka in Parliament reminded the nation, reclaiming collective voice and whakapapa truth is both ancient and urgent (Williams, 2025).

Current inequities in reproductive health for Māori are not incidental — they are breaches of Te Tiriti and protected rights under international frameworks such as the UNDRIP. The voices in this theme reinforce the critical role of Mana wāhine and tino rangatiratanga in birthing spaces, aligning with Te Tiriti based claims and political discourse on bodily sovereignty (Mana Wāhine Kaupapa Inquiry, 2023; Waitangi Tribunal, 2023b).

A participating kuia highlighted how tapu is both embodied and protective, shaping how wāhine engage with health systems: "*A lot of Māori women weren't getting their cervical smears, ... our clinic improved smear rates... once you could smear yourself... we know our bodies are tapu and we don't like to allow anyone to touch them or see them… That's what was stopping us from getting smears... and when you have a baby, where you're forced to let all in Sundry*

have a look at your bits... luckily we can choose our midwives, somebody that we feel safe with"...

Yet through ongoing disconnection from cultural knowledge, wāhine are often denied the opportunity to learn what is tika, what they are entitled to expect, and how to recognise breaches of tapu. Participants expressed deep concern about the delivery of Kaupapa Māori sexual and reproductive education within mainstream schools, describing how Eurocentric institutions have mishandled sacred knowledge — stripping it of its depth and integrity.

"They can't be trusted to hold our sacred teachings when they've failed us in every other way" — wahine participant.

Tāne also spoke to the long-term impacts of this absence: *"Without this kind of awareness, there would be a lot of fear of [my kōtiro] growing up and stepping into womanhood… without my own positive male role models to educate myself around the sacredness of sex… it's all just physical. Like the wairua dimension to that sacred act and around the ikura… my whakaaro when I was younger was just damn! I couldn't have sex. That was all I thought about. Honestly, and to now know what it is, what depth lies there compared to – I felt like a dickhead, but that's where I was at"* - tane participant.

Another tane participant connected these personal stories to systemic suppression: *"When you go back to what's the role of tāne and wāhine… all of what we're talking about is speaking to the disconnection from wairua, and I believe the system fears the rise of Te Reo Māori. I believe the fear is dropping the mind and opening the heart, because that's what's required in order to tap into wairua. And to do that you've got to face the mirror… our role in regard to maintaining Te Whare Tangata starts with wairua. An aligned person who's connected is going to want to look after themselves, a disconnected person doesn't look after themselves".*

These reflections are echoed at a systemic level. Shaw and Tudor (2023) argue that health professional regulatory bodies in Aotearoa are beginning to recognise that cultural safety is not a static skill but an ongoing, relational commitment to addressing racism, power imbalances, and the impacts of colonisation. This signals that Māori-led spaces such as wānanga are not supplementary but essential to restoring equity and trust in health systems. Whānau were clear, however, that the system itself is still resistant:

"they [health professionals & health systems] have to say that their way is not working, and that's a hard thing to admit for anyone" - wahine participant.

"The systems are in place to put up those barriers… to be incorporated in our today's world, to be incorporated into the clinical midwife system" – tane participant.

When asked what their whānau, schools, or professionals had taught them about the sacredness of Te Whare Tangata, participants collectively replied *"nothing"* — to which one tane added *"next question,"* prompting overall laughter. This lightness opened the door to deeper reflection.

"I thought really hard on this. The only time I remember anyone was from you [Kaniwa – primary researcher] at a wānanga you did two years ago. That was the first time in my life that I experienced a breakthrough around understanding the sacredness of Te Whare Tangata" - wahine participant.

A second wahine participant described how intergenerational knowledge sometimes arrived in fragments: *"My aunty would drop these little gems… she was always planting seed into our consciousness… like she could see we're sleeping [unconsciously living]".*

For others, visiting aunties became full whare wānanga in themselves: *"We had quite a comprehensive experience of learning about everything from our Aunty because… it just so happened we were all having a holiday. All of us young cousins and one of our oldest cousins got her ikura. So that became a wānanga for all of us girls. She told us all about ikura and also that then jumped into babies. She explained everything about babies, how babies are created, and where they come from. I think I might be eight years old… at that age, you're not scared, you've got no preconceptions or judgements against it because you're too young. It's not until you get older, then you get hang-ups. But at that age, you just absorb it, and it's not scary"* – kuia participant.

Another kuia participant added: *"Not long after our ikura kōrero, we actually had a baby. The first mokopuna came along, we all became aunties, so it was very important for us".* For her, the experience affirmed the continuity of collective learning: *"So our whole lives were a wānanga".*

The regulatory endorsement of cultural safety as a professional competency reinforces what these wāhine already knew—that safe care must be grounded in trust, whakapapa, and cultural integrity (Midwifery Council of New Zealand, 2021, 2022). The Code of Conduct states that midwives must recognise and address power imbalances, uphold mana-enhancing relationships, and ensure that culturally safe care is defined not by the practitioner, but by those receiving care (Midwifery Council, 2022, p. 7). This aligns with this study's findings, where wāhine described unsafe care as care devoid of recognition for whakapapa, tikanga, and wairua.

The kōrero gathered detailed the need to be culturally held, intergenerational learning spaces grounded in marae, whakapapa, and tikanga. Within these spaces, wānanga becomes

ceremony — a living exchange between generations and realms, restoring tapu and whakapapa as the foundation of wellbeing. Sleeping among ancestors, sharing kai and karakia, or cleansing in the awa are not separate acts but continuations of the same sacred rhythm that sustains Māori life.

At Hiruharama Marae, these principles are lived daily — through wānanga, mirimiri, and wahakura practice, through birth and death, through the re-emergence of moko kauae upon ancestral faces. Each act restores mana wāhine and returns Te Whare Tangata to its rightful place: central, sovereign, and alive.

Whānau participants described the marae as both mirror and threshold: *"Our marae is the beginning and the stepping stone through the tapu... it helped to weave us as human beings, become better... deepen our understanding, level of respect and integrity, surrounded by our tipuna, the marae is our mirror" - tane participant.*

"Straight away, it's bringing up stuff, realising that the pare you're walking under is like your tipuna's whare tangata, blessing you as you come in, it's the first thing that you do" - wahine participant.

A kuia participant added: *"As soon as you step through the mahau, he tapu tonu – because what lies ahead of you, what challenges you think of just before a tangi, there's many things getting spilled into that paepae, you've got to be aware of, there's all sorts of things that entails on the marae".*

And another tane explained: *"Or the tikanga too, of that whare tangata. Once we step out of that zone — like on a maunga, in an awa or moana — that blueprint of our tikanga and kawa that we have on a marae, that's pretty much the same tikanga and kawa everywhere you go… the designing of our karakia tapu and everything comes from us".*

"The core of everything about us as iwi Māori, comes from Te Whare Tangata" - tane participant.

"Because we want to be alive to see our mokopuna, we're gonna do like physical, mental, emotional... we've got to look after all of those aspects of ourselves, what it means to be a human being... it's an ancient art form, it's been here since the dawn of time, and so this is not new"... - wahine participant.

The growing visibility of wāhine Māori receiving moko kauae in Tairāwhiti and across Aotearoa signals not only cultural resurgence, but a profound reclaiming of bodily sovereignty and collective identity. As Dewes (2019) observes, the normalisation of moko kauae on the faces of wāhine is a declaration of whakapapa that inspires strength in others. To birth, to wear

moko, and to grieve are all thresholds of transformation — crossings into deeper realms of knowing and being. The rise of moko kauae represents a spiritual return to self and to collective consciousness (Pihama, 2018; Dewes, 2019). These markings affirm wāhine Māori as kaitiaki of life and death, deserving of birthing systems that honour the sacredness of Te Whare Tangata and its interconnected realities. As Pihama (2018) affirms, moko kauae is the inherent right of wāhine Māori, a political and spiritual act of tino rangatiratanga that embodies the strength of your tīpuna and opens pathway for your uri to stand proudly in their sovereignty.

"[learning about this kaupapa and participating in this wānanga is an] evolution of consciousness' - tane participant.

At this wānanga, I honoured my tīpuna in our urupā and within Kapohanga-a-Rangi. Inside the wharenui, I re-studied the kōwhaiwhai and tukutuku panels as the inner walls of her womb — each pattern carrying expressions of whakapapa, each symbol a navigational portal to higher realms of learning. With my midwifery eyes and atua wāhine heart, I understood these messages as instructions for the transformation of maternity care.

"Our tipuna are behind the scenes, weaving that baby to become that baby… it's in their DNA" — tane participant.

This kōrero reflects a deep cosmological belief in intergenerational presence within Te Whare Tangata. To say "it's in their DNA" acknowledges whakapapa as a spiritual and genetic continuum, one that rejects western compartmentalisation of science and spirituality. It speaks to the active presence of tīpuna in the formation of life, underscoring the necessity of birthing models that embrace not just clinical evidence, but whakapapa knowledge systems.

This wānanga reconnected and strengthened intergenerational whānau bonds - affirming existing ties while weaving new relationships into the fabric of whakapapa. I brought back my teina to weave a wahakura alongside another whanaunga, expressing our healing in physical form—a taonga that emerged from wānanga.

As Paringatai and Wharerau (2021) affirm, tūnga ki te marae, tau ana—when one stands on their marae, one finds peace. The marae, as a site of cultural memory and reclamation, holds the spiritual and social infrastructure to foster hauora and transform intergenerational narratives. The Māori-Centred Approaches report (n.d.), echoes this, noting how marae-based rangahau generates deeper engagement and emotional resonance, reactivating ancestral memory and collective empowerment. At the same time, tikanga is shaped by mana whenua. What is tika in te Tairāwhiti may not be tika elsewhere. As Gillies and Barnett (2012) remind

us, cultural authority in maternal health is place-based and requires deep relational accountability to whenua, whakapapa, and lived practice.

My whakaaro therefore offers mātauranga shaped by my lived experience, the teachings of my whānau and elders, and my years of midwifery practice. These insights are not universal, but grounded in a whakapapa-driven, place-based framework that honors the land, the people, and the sacredness of Te Whare Tangata.

"DNA is meant to be a physical representation of the codes from wairua, of all existence" — tane participant.

Wānanga on the marae reconnected participants to whakapapa as living practice. Within these spaces, ancestral memory was reawakened, intergenerational bonds were strengthened, and embodied knowledge was restored to its rightful place. The marae was not simply a venue; but a sacred medium of transformation, where cultural authority, spiritual safety, and tino rangatiratanga were enacted in real time.

These kōrero affirm that Māori-led spaces of learning are not supplementary but essential. They anchor whānau within their own cosmologies, protect against the erasures of colonisation, and reassert collective sovereignty over Te Whare Tangata. As participants reflected, to learn within the embrace of the marae was to be mirrored by tīpuna, guided by tikanga, and repositioned within the continuum of whakapapa.

This chapter has returned us to the wharenui, where te whāriki of Hine-te-Iwaiwa was carefully examined through the lived experiences of wāhine, tāne, and whānau. Each theme revealed a distinct strand of this weaving: the disconnection of wairua within colonial maternity systems; the sacred pulse of wāhine as vessels of whakapapa; the reclamation of ancestral technologies and cosmological practices; the role of midwives as sacred witnesses within Te Whare Pora; and the marae as whare wānanga where intergenerational knowledge is restored. Together, these threads reveal both the ruptures and resilience carried within Te Whare Tangata.

Table 4.5.1: Summary of themes, subthemes and implications.

Theme (Whāriki Strand)	**Key Subthemes / Illustrative Ideas**	**Analytic Insight**	**Implications for Midwifery, Policy, and Practice**
4.1 Te mokemoke o te Wairua: Reclaiming Wairuatanga in Te Whare Tangata	• Spiritual loneliness in clinical settings • Disconnection from tikanga	Absence of wairua in hospitals constitutes spiritual harm and	Embed spiritual safety (karakia, tikanga, whānau presence) as clinical norms; redesign birthing

	• Resistance and reclamation	breach of tino rangatiratanga.	spaces to uphold wairua and whakapapa.
4.2 Te iho o te ao: The Sacred Pulse of Wāhine	• Wāhine as cosmological vessels • Epigenetic inheritance • Fear vs trust • Whenua & ikura rites	Te Whare Tangata is biological and cosmological; the body as an intergenerational portal.	Integrate wairua-led antenatal education; align maternity care with lunar rhythms and embodied sacredness.
4.3 Te ara whakaora o Te Whare Tangata: Reclaiming the lineage.	• Ancestral technologies (rongoā, oriori, taonga pūoro) • Collective healing • Global Indigenous resurgence	Healing requires reactivation of ancestral technologies and relational care.	Fund Kaupapa Māori birth education and rongoā integration; Māori-led birthing units;support rangahau on ancestral healing.
4.4 Te Whare Pora o Hine-te-Iwaiwa: Weaving sacred witnessing in Midwifery	• Midwife as kaitiaki • Wairua-led clinical presence • Professional depletion • Workforce equity	Midwifery is sacred witnessing; equity demands spiritual and structural reform.	Strengthen Māori midwifery workforce, embed Tūranga Kaupapa training, recognise spiritual labour in remuneration and policy.
4.5 Whare wānanga ki tōna marae: Reclaiming intergenerational knowledge, strength and sovereignty	• Marae as transformative space • Intergenerational learning • Moko kauae • Whakapapa education	Marae-based wānanga re-activate tino rangatiratanga and intergenerational authority.	Resource marae-based maternity and education initiatives; recognise marae as legitimate health and rangahau environments.

Across the kōrero, one truth resounds: wairua care is not an adjunct to maternity services but the very foundation of hauora and whakapapa continuity. When absent, systems silence Mana wāhine and sever ancestral bonds; when present, they restore safety, dignity, and tino rangatiratanga.

Together, the five themes reveal a complete whāriki — tracing both rupture and renewal within Te Whare Tangata. Healing, they show, requires more than clinical reform; it calls for spiritual realignment- the reactivation of tikanga, wairua, and whakapapa as living systems of care. In this sense, Chapter Four has been a written wānanga — ceremony, critique, and testimony woven together to restore balance.

For participants, wānanga reawakened belonging and confidence to carry ancestral teachings forward. For me as researcher, it redefined analysis as an act of aroha — where rigour and ceremony coexist, and knowledge itself becomes healing. Within that shared space, grief and insight were exchanged in equal measure; tears and laughter became analytical tools as much as words. Wānanga methodology thus enacted the very principles it sought to study – restoring wairua, deepening relational trust, and manifesting Te Whāriki o Hine-te-Iwaiwa.

As we move into Chapter Five, Te Whāriki o Hine-te-Iwaiwa rests within the wharenui — resonant with whānau voices and ancestral guidance. The next chapter turns toward the work of strengthening and repair: gathering the materials needed to weave new threads of practice, policy and pedagogy. Drawing on these collective insights, it envisions how maternity care in Aotearoa can be restructured to uphold wairua, whakapapa, and the mana of wāhine as Te Whare Tangata — ensuring that the legacy of Hine-te-Iwaiwa continues to guide us toward balance, integrity, and collective wellbeing.

Chapter Five: Te otinga o Te Whāriki o Hine-te-Iwaiwa | Weaving the pathway of return: Final discussion and destination | The ceremony of closure and renewal.

Te awatea approaches; the last twinkling stars glimmer above Kapohanga-a-Rangi. Birdsong begins across the ātea as karakia tīmatanga settles into the carved ribs of our tūpuna. I gather Te Whāriki o Hine-te-Iwaiwa, fold it carefully, and stand at the mahau, feeling the lingering hum of kōrero. This final chapter gathers those insights and carries them forward - weaving them along the ridgelines of the land so that what was spoken in wānanga may now move into the world.

Here, theory, methodology, and lived kōrero converge. Chapter Five ascends from te awatea – the dawn of renewal, translating wānanga into action and vision. It brings the findings into conversation with Māori health reform, midwifery education, and Te Tiriti obligations, asking: How can maternity systems in Aotearoa be re-woven through wairua, whakapapa, and whānau ora? The journey that follows mirrors the ascent of Hikurangi — each step a phase of reflection, clarity and renewal.

Section 5.1 begins at the foundation, exploring Whānake whakapapa and the revival of Poutama rites of passage as education and ceremony. Section 5.2 moves into the body of practice, illustrating mana-enhancing care and the integration of rongoā within hapūtanga. Section 5.3 turns to the wider whāriki of whānau ora, tracing tapu, Tūpuna parenting, and Te Aho Matua as intergenerational infrastructure. Section 5.4 gathers these elements together under the principle of wairuatanga, framing it as the guiding logic for finance, leadership, and workforce wellbeing. The final sections — 5.5 to 5.8 — draw the pattern taut: revisiting the rangahau questions, articulating recommendations, acknowledging limitations, and returning the mauri of this work to Hine-te-Iwaiwa. This way, Chapter Five completes the cyclical journey begun in Chapter One — from whakapapa to praxis, from rangahau as inquiry to rangahau as offering.

From Hiruharama Marae, I follow the meeting rivers — the clear currents of Makatote joining the blue-white body of the Mata before flowing east to the Waiapu — until Hikurangi rises ahead, the sacred maunga of Ngati Porou, standing as living atua and ancestor. In our cosmology, she was the first part of Te Ika-a-Māui to surface when Māui hauled the great fish from the depths (Tairāwhiti Trails, n.d.). Her peaks still bear the imprint of his hook, carrying the reverberations of karakia from tūpuna, whānau, midwives, and healers — from those labouring to bring pēpi into te ao Mārama, to those guiding loved ones through the same celestial doorway. Within the celestial order described by Chadwick and Paviour-Smith (2017), Taramainuku casts his kupenga net to gather returning spirits, carrying them toward the Matariki constellation before releasing them to the Pohutukawa star. Hikurangi maunga stands

as a bridge between realms — the mountain that receives our breath and returns it as echo, binding sky and land in perpetual conversation.

A tribal mōteatea, Hikurangi Maunga Kāti Rā, adapted by Hānara Tangiia (Arnold) Reedy upon the death of Sir Apirana Ngata (Koti, 2013), affirms this guardianship — Hikurangi as kaitiaki of passage between Papatūānuku and Puanga, a star within the Tautoru constellation where Taramainuku resides (Chadwick & Paviour-Smith, 2017). From her slopes, the living and the departed meet: those returning to the heavens, those descending as new wairua through labouring mothers, and those who stand between — whānau, midwives and healers— holding vigil at the threshold. In her presence, breath and wind, oriori and tangi, arrival and return are woven together — each movement finding safe passage through the body of the land and the heart of the heavens.

This whakapapa also speaks through pepeha, guiding wāhine to climb their maunga to retrieve their pēpi — to ascend through the celestial realm and return, pēpi in arms, to deliver them into te ao mārama. It is a journey only they can make.

As I climb higher, the air thins and the sky brightens, the wind hums across rock like a loom string. At the summit stand nine pou, eight male carved ancestors of Māui's deeds and the ninth, Hine-rau-ma-Ukuuku, weaver of regenerative knowledge and guardian of growth (Maunga Hikurangi, 2024). At each pou I stop, breathe and acknowledge — Whakapapa, the foundation of knowing; Wairua, the breath that endures; Tinana, the sacred house of spirit; Hinengaro, the mirror of thought; Whānau, the first and last healers; Whenua, placenta and place; Mauri, the pulse of life; Mana Wāhine, the enduring scaffold; and Hine-te-Iwaiwa, luminous at the lunar edge, steadying the hand that weaves birth and knowledge (Pere, 2006; Mikaere, 2011).

Here, beneath their watch, I unroll the whāriki once more. Threads spill like dawn — each a voice from the wharenui below, each question pressed forward by care:

- How do we protect the sacred bond between māmā and pēpi?
- How do we restore wairua to the centre of practice unapologetically?
- How do we build systems that remind people are not throughput?

The wind answers softly, reminding me that the pattern reveals itself only when the hands are honest and the words remain accountable to those whose breath carried this work here. Thus begins the final weaving — the translation of wānanga into action. The climb becomes a metaphor for restoration: as each step nears the horizon, theory, methodology, and lived kōrero converge.

What follows interprets the pattern revealed on Hikurangi — a constellation of spiritual, structural, and educational reforms interlaced within Te Whāriki o Hine-te-Iwaiwa to guide the evolution of Kaupapa Māori midwifery in Aotearoa. The kōrero shared in Chapter Four revealed both rupture and renewal — how colonisation fractured wairua in birth yet how whānau are restoring it through ceremony, education, and leadership. The following sections translate those insights into action, beginning with the foundations of learning and identity.

5.1 Whanake whakapapa | Advancing Poutama Rites of Passage.

Tracing how Māori philosophies of learning and ceremony shape the beginning of life itself, this section explores how advancing the ancestral curriculum of Hine-te-Iwaiwa, guides rangatahi, wāhine, and whānau to prepare spiritually, physically, and collectively for relationships, intimacy and parenthood. By linking ancient Kaupapa Māori pedagogies within contemporary wānanga such as Poutama Rites of Passage [PRoP], this section demonstrates that education is a powerful source of transformation that sustains the kaitiakitanga and continuity of whakapapa across generations.

The Framework of Integrated Reproductive and Sexual Health Theories (FIRSHT) positions reproductive health within a life course continuum, recognising that experiences before conception shape maternal and infant wellbeing (Liddell & McKinley, 2022). From this view, reproductive education should begin before conception, with antenatal education serving as a refresher on foundational knowledge. Challenger (2013) explains how our tūpuna understood this through poutama — the ascending pattern that embodies lifelong learning and transformation, each step a stage of growth supported by whānau and community, reflecting an Indigenous pedagogy of continuous ascent and renewal (Pere, 1991; Pihama et al., 2014). Poutama was not metaphor but method — a pedagogical and spiritual scaffold guiding rangatahi to recognise bodily sovereignty, relational balance, and the sanctity of wairua.

The Poutama framework of holistic wellbeing, connects rangatahi through whakapapa, mentorship and relational health (Waikato Wellbeing Project, n.d.). Within these wānanga, learning platforms explore the intergenerational impacts of trauma and how atua cosmologies guide healthy relationship, menstrual literacy, body confidence, spiritual awareness, intimacy, and sacred embodiment (MyCup, n.d.; Stuff, 2019). Together these initiatives show how PRoP remains a living educational philosophy, continually adapting to nurture identity, balance, and intergenerational connection.

Today, PRoP carries these ancestral teachings forward through a Kaupapa Māori, community-led model that supports whānau through major life transitions, reinforcing communal responsibility for our future leaders (Raglan Chronical, 2023). Facilitator training prepares adults and rangatahi to guide these journeys within their own communities, grounded in

kanohi-ki-te-kanohi relationships and the belief that transformation begins within hāpu. Three-to-five-day wānanga for taitama and kōhine call upon atua and the natural elements to foster growth through story, challenge, and reflection.

On 2 October 2020, I attended a PRoP E hine wānanga at Hine-Tamatea Marae in Anaura Bay, facilitated by Rawinia Kingi and other tino ātaahua tuakana. The depth and integrity of the kaupapa moved me profoundly. I witnessed kōhine guided by wāhine and kaimahi who wove Papatūānuku, atua wāhine, marama, whenua, and Te Whare Tangata into every experience. The space radiated aroha and discipline - generations leaning in to support them. With permission from writer-director Becs Arahanga, we watched Hinekura, a short film released in 2019 that features Ngati Porou actors re-enacting the traditional blood rites of wāhine in the 1600's (Arahanga, 2023). Through Hinekura, the kōhine saw their own bloodlines mirrored back to them — an embodied reminder that menstruation, fertility, and creation are woven through atua, whenua, and whakapapa. The film grounded the wānanga in visual whakapapa and affirmed that PRoP is a ceremony made contemporary - living curriculum that re-aligns people, place, and purpose (Kupenga-Tamarama, 2020).

This study's wānanga participants issued a warning: when non-Māori facilitators attempt to teach this sacred knowledge without whakapapa connection, mistrust and spiritual discomfort arise. Many participants expressed reluctance toward institutional programs that claim inclusivity yet remain detached from whenua and wairua. Preserving these teachings therefore requires that their guardianship stay with Māori educators who carry genealogical and spiritual authority — ensuring Te Whare Tangata knowledge is not extracted or commodified through western frameworks.

Rangahau with rangatahi Māori supports this view. Biomedical sexuality education—often centred on anatomy, consent, and contraception—fails to meet Māori needs because it divorces sexuality from whakapapa and wairua (Le Grice & Braun, 2018; Russell et al., 2013). Rangatahi consistently call for learning grounded in whanaungatanga and humour, where consent, pleasure, and respect are taught as acts of mana. However, the Education Review Office (2024) found that national delivery of Relationships and Sexuality Education remains inconsistent, culturally thin, and heavily dependent on individual schools' goodwill. This fragmentation leaves Māori students under-served, learning about bodies without learning about belonging.

PRoP offers a remedy. It demonstrates how education can once again become ceremony—relational, embodied, and spiritually safe. By embedding PRoP principles within a national hapūtanga wānanga curriculum, Aotearoa could create a continuum of learning that begins before conception and continues through adolescence, pregnancy, and parenting.

Such a framework would re-establish education as sacred preparation, restore whānau and whenua as teachers, and ground learning in wairua and Mana Wāhine. This responds directly to the whānau voices in Whare wānanga ki tōna Marae, who described wānanga as sites where ancestral knowledge is restored and collective teaching of whakapapa renewed.

In doing so, we honour Hine-te-Iwaiwa's original curriculum — the woven poutama of cosmology, ethics, and practice that guided our ancestors and continues to light the path for whānau today. From this foundation, the next strand of the whāriki turns toward care itself: how rongoā, tikanga, and mana-enhancing practice restore balance within maternity and sexual-health systems.

5.2 Mana-enhancing care and rongoā in the hapūtanga journey.

This discussion builds upon the previous section by examining how Māori philosophies of education strengthen whānau before their direct engagement with the maternity system. It explores how manaakitanga, whakawhanaungatanga, and rongoā interweave to form a framework of mana-enhancing, culturally safe care for wāhine and whānau throughout the hapūtanga journey. By weaving contemporary evidence with Indigenous knowledge, this section shows how rongoā Māori and relational practice translate Kaupapa Māori theory into lived clinical ethics.

Mana-enhancing care is the ceremony of practice. Within maternity and sexual-health care, manaakitanga and whakawhanaungatanga are not soft gestures but the clinical ground of safety and trust. Wāhine in recent studies described care as either te hāpai i te Mana wāhine—lifting their dignity—or te takahia i te Mana wāhine—trampling it.

Cultural safety, first articulated by Māori nurses, remains the foundation of mana-enhancing care (Ramsden, 2000). A qualitative review of patient-defined cultural safety in perinatal interventions found that safety was created when care acknowledged cultural difference, was delivered within the community, and respected women's choices and local knowledge (Egger et al., 2024). Harris et al. (2025) further explain that the difference was felt from the doorway: a private, welcoming space; clinicians who opened kōrero gently around contraception, miscarriage, and wellbeing; and encounters long enough to affirm personhood rather than process. Wāhine felt trust when clinicians asked about tikanga, included whānau, and validated decision-making. Where these threads were missing, wāhine reported whakamā and withdrawal; when present, they found safety and healing (Harris et al., 2025).

Together, these findings position cultural safety as the connective tissue between quality maternal and newborn care, person-centred practice, and high-functioning health systems — reframing dignity, agency, and community support as measurable quality indicators.

Embedding Kaupapa Māori and Mana wāhine frameworks across all maternity services therefore enables wāhine and whānau to experience their legislative right to safe, culturally grounded care.

Indigenous psychologies position sexuality and reproduction as taonga and relationships as tapu-ki-te-tapu — spiritual, relational, and ecological acts (Le Grice & Braun, 2018). Sexual and reproductive decision-making are extensions of whakapapa ethics; when guided by care, respect, and positive sexual agency, they restore balance to Te Whare Tangata. Within this worldview, forms of rongoā Māori — including mirimiri, wai or wairākau, karakia, and oriori — are not "complementary" but Treaty-protected healing practices that safeguard attachment, bodily sovereignty, and the māmā–pēpi bond while meeting biomedical needs with integrity.

Evidence across Indigenous nations echoes this understanding. A trans-Indigenous scoping review spanning Australia, Aotearoa, Canada, and the United States found that most "pre-conception health" rangahau focuses narrowly on biomedical risk while neglecting men, whānau, and culture (Walker et al., 2024). The authors call for life-course, whānau-centred care integrating culture and measuring outcomes that matter to Indigenous peoples — an agenda already realised through hapūtanga wānanga and rongoā-based practice.

Perinatal mental health evidence echoes this need. A global synthesis identified six strands of success: skill-building, social support, trusting relationships, Indigenous self-determination, customary practice, and identity (Meredith et al., 2023). The most effective programs wove these strands through He Awa Whiria methodologies, allowing Western and Indigenous knowledges to flow side by side. Such approaches inform that healing must arise from whenua and whakapapa, led by those who carry the tikanga of Te Whare Tangata.

Strength-based international evidence further demonstrates that restoring cultural identity and resilience improves perinatal outcomes. A narrative review identified four recurring pillars: home visiting and family support, perinatal mental health initiatives, breastfeeding promotion, and Indigenous midwifery or doula services. Across contexts, culturally matched, family-centred care reduced pre-term birth, low-birthweight, and postpartum depression (Biermann & Strahm, 2025). The authors concluded that Indigenous midwifery, collective ceremony, and culturally adapted education remain the most effective levers for maternal resilience and survival — yet are chronically under-resourced.

Local voices confirm the same pattern. Māori mothers' experiences of antenatal care identified five determinants of wellbeing: mana motuhake, identity, holistic wellbeing, continuity, and whakawhanaungatanga (Below, 2024). When clinicians upheld mana motuhake through active listening and advocacy, wāhine felt safe; when tikanga or rongoā were dismissed, trauma and mistrust followed. Identity-affirming care delivered by Māori midwives, anchored

in whānau participation, karakia, and wairua - was consistently experienced as restorative. These findings verify that manaakitanga and wairuatanga are clinical competencies, not cultural niceties.

Evidence from hapū wānanga reinforces this truth. Analysed through a Te Wheke lens, Kaupapa Māori antenatal education was found to activate all eight tentacles of wellbeing — wairua, hinengaro, tinana, whānaungatanga, whatumanawa, mauri, mana atua ake, and hā ā koro mā ā kuia mā (Hawaikirangi, 2021). Participants described mainstream classes as alienating and clinical, whereas Hapū Wānanga created mana-enhancing, whānau-centred experiences where karakia, mirimiri, and pūrākau re-connected participants to tīpuna. The dimensions most associated with wellbeing were whānaungatanga and hā ā koro mā ā kuia mā, reaffirming that spiritual lineage is a determinant of health.

Yet, even within a high-income nation, Māori maternal realities mirror low-income inequities. Globally, 700 women die each day from pregnancy-related causes — one every two minutes — with 92% of deaths in low-income countries (World Health Organization [WHO], 2025). In Aotearoa, decades of neoliberal reform and widening wealth disparity have produced similar forms of structural deprivation. Over one million New Zealanders live in hardship; a quarter in severe hardship (Carroll et al., 2011). The top 20% of households hold 70% of wealth, while many in the lowest quintile have negative net worth (Business and Economic Research Limited, 2020). These imbalances manifest as overcrowding, food insecurity, and limited access to culturally safe care — the very determinants of maternal and infant mortality (Heck et al., 2025).

Recent analyses confirm the scale of inequality. New Zealand's wealthiest citizens now pay proportionally less tax than their OECD peers, while redistribution through welfare fails to close the gap (Campbell-Hunt, 2024). O'Brien (2025) reports that one-in-ten tamariki live in persistent poverty and one-in-four experience food insecurity, with tamariki Māori three times more likely to live below the poverty line. These conditions erode whānau wellbeing before conception, reproducing inequity across generations.

Longitudinal data from Growing Up in New Zealand deepen this picture: over half of mothers with chronic illness or disability live below median income, and 43% rely on government payments by their child's eighth birthday (Huang et al., 2022). Tamariki in these households exhibit higher emotional and behavioural difficulties, demonstrating how poverty and maternal ill-health intertwine. Among Māori and Pasifika whānau, however, strong cultural identity and whanaungatanga buffered many effects, proving that wairuatanga and whakapapa connection function as protective rongoā, though they cannot compensate for structural neglect.

UNICEF Aotearoa (2025a, 2025b) reports expose the national paradox: New Zealand ranks thirty-two out of thirty-six OECD and EU countries for overall child wellbeing and last for mental wellbeing. Material hardship, housing unaffordability, and rising hospital admissions reveal that "third-world conditions exist within a first-world country." These indicators confirm that inequities in maternal and infant wellbeing are not isolated health issues but outcomes of political economy. Collectively, these compounding, complex revelations confirm the urgency of Kaupapa Māori transformation — where wairua, manaakitanga, and equitable resource distribution are treated as the true infrastructure of health.

The move toward mana-enhancing, rongoā-centred practice parallels global calls for mother-centred health promotion. Aotearoa rangahau engaging 268 maternity stakeholders identified five key pathways: community-owned systems, skill development and inclusive education, upstream structural equity, mother-centred funding, and creation of a collective "mothering village" (Neely & Reed, 2023). Participants envisioned marae-based hubs, equitable rongoā and postpartum funding, and social infrastructure that holds mothers—not only infants—at the heart of policy. Their conclusion is clear: re-orienting maternal care toward whānau-led, spiritually grounded models is the practical expression of mana-enhancing health promotion (Neely & Reed, 2023).

Taken together, this body of evidence redefines best practice. Mana-enhancing, wairua-centred, rongoā-integrated maternity care is not alternative—it is evidence-based, Treaty-aligned, and cost-effective. When services are locally led, spiritually grounded, and relationally held, both cultural and clinical outcomes improve. Embedding Kawa whakaruruhau and the Meihana Models across curricula , guaranteeing Māori representation in perinatal governance, recognising Rongoā practitioners as core team members, and designing spaces where karakia and consultation coexist with clinical expertise are not aspirations — they are obligations (Matenga & Westenra, 2022).

Above all, mana-enhancing care means designing systems that protect the mana motuhake of wāhine and whānau, so that birth, death, sexuality, and reproduction are again held within the sanctity of Te Whare Tangata.

5.3 Enriching whānau ora | Tapu whilst hapū, Tūpuna parenting and Te Aho Matua.

This discussion applies the spiritual, philosophical, and relational principles outlined in the literature review to the lived realities of maternity care in Aotearoa. It explores how 'Tapu whilst Hapū', Tūpuna Parenting (n.d.), and Te Aho Matua (TRNoNKKMoA, 2008), operate as interconnected strands of a Māori health system grounded in wairua and whakapapa. While earlier chapters established these frameworks theoretically, this discussion brings them into

dialogue with contemporary challenges such as alcohol, vaping, and digital marketing—modern manifestations of colonisation that continue to test the sanctity of Te Whare Tangata. Through case studies of harm and examples of Māori-led restoration, it demonstrates that tikanga endures as both ethic and methodology: protecting life, sustaining balance, and guiding the pathway toward whānau ora.

Whānau ora is the natural outcome when whakapapa is honoured from its first heartbeat — beginning with the tapu of hapūtanga and sustained by Tūpuna Parenting (n.d.), and the educational threads of Te Aho Matua. To speak of 'Tapu Whilst Hapū' is to acknowledge the sacred state that descends when a new whakapapa line forms within the body. Recognising this sanctity transforms clinical care into ceremony; every encounter becomes a wānanga—karakia before assessment, humour that softens fear, and consent that restores dignity. Whaanga (2024) describes wā as the river of wairua carrying past, present, and future as one current. To live well is to move in rhythm with that flow, aligning mana with 'te tapu i te tangata'—the divine spark shared by all. Hēnare (2015) deepens this with a Māori philosophy of vitalism where tapu, mana, mauri, hau, and wairua operate as interdependent forces. Pregnancy and birth thus become acts of cosmic maintenance — the same laws that govern stars, oceans, and forests govern the womb.

The principles that sustain Te Whare Tangata are the same that nurture Te Whare Ako. Recent findings from the New Zealand Qualifications Authority show that tamariki educated within Kura Kaupapa Māori achieve higher NCEA attainment across levels one to three, compared with their peers in mainstream schooling (Klinkum, 2024). These results affirm that wairuatanga and Mana wāhine are powerful determinants of wellbeing – in both health and education. Yet the current government is actively unravelling the protective rights guaranteed to Māori under Te Tiriti through health and education reforms — including the proposed reinterpretation of Treaty principles, the disestablishment of Māori-led structures, and the removal of te reo Māori from early learning resources — signalling a regression from partnership to paternalism (MacKintosh, 2024; Marston, 2025; Torre, 2025).

This understanding invites reflection on the systems that either sustain or disrupt this balance. Current benefit and tax-credit structures provide sole parents with roughly the same weekly income as a full-time minimum-wage earner, while the equivalent in childcare subsidies for two children can exceed this amount (Work and Income NZ, 2025; Inland Revenue NZ, 2025; Employment NZ, 2025; Living Wage Movement Aotearoa NZ, 2025). Highlighting an economic imbalance of structural paradox in social policy: the state invests more in institutional childcare than in the mothers who provide it. Rangahau confirms that tamariki experience optimal brain and emotional development when they remain closely connected to their māmā during the first

three years of life (Kamana, 2024; Ngāpō & Kingi, 2024). From a reproductive-justice perspective, equitable policy must value maternal presence as vital national infrastructure, aligning fiscal design with whakapapa ethics and the mauri of Te Whare Tangata.

The relationship between traditional birthing and parenting practices, spiritually centred learning, and Māori wellbeing underscores a wider truth: if wairuatanga can uplift educational outcomes, and spiritually grounded maternity care enhances optimal health, then embedding these protective practices is an urgent necessity for our whānau, community and economy. As discussed in Chapter Two, Māori comprise just under 18% of the total population yet around 25% of the birthing population, with one-third of Māori aged under 30 years (Stats NZ, 2025; Health New Zealand, 2025a). Over the next two decades, this youthful demographic will bring an expanding generation of whānau into maternity and early-years care. Ensuring that these whānau encounter systems reflecting their worldview is therefore a matter of equity and national sustainability.

In this way, Te Aho Matua and Hine-te-Iwaiwa converge. The same pedagogical and spiritual principles that nurture confident tamariki can re-shape reproductive justice in Aotearoa. Grounding maternity and parenting policy in Kaupapa Māori practice extends beyond birthing care into parenting, sexual-health education, and workforce training. It also speaks to the realities faced by wāhine Māori raising tamariki in an inequitable system—where, paradoxically, others may receive greater financial support to care for their tamariki than mothers themselves. Early-childhood rangahau confirms that the first three years of life are critical for optimal attachment and neural development (Kamana, 2024; Ngāpō & Kingi, 2024); policies must therefore honour this bond, value maternal presence and uphold whakapapa as a core national wellbeing priority.

Recent maternity evidence echoes this call to culturally grounded, relational care. Hayward et al. (2025) found that wāhine Māori often experience racism, fear, and a lack of trust with midwives. They recommend implementing frameworks such as Te Hā o Whānau and enhancing training in tikanga, cultural safety, and whānau-centred practice.

Developed from Kaupapa Māori research with whānau who experienced perinatal loss, Te Hā o Whānau provides practice guidelines grounded in manaakitanga, rangatiratanga, and whakawhanaungatanga (Stevenson et al., 2020). These principles place compassion, autonomy, and relationship at the heart of safe maternity care. Manaakitanga nurtures cultural safety through karakia, whānau inclusion, and genuine respect. Rangatiratanga restores parents' authority and choice, while whakawhanaungatanga reframes the clinical encounter as a shared relational space that honours place and connection.

Together, these insights show that without whanaungatanga and manaakitanga, wellbeing cannot be achieved—and that strengthening a Māori midwifery workforce educated within Kaupapa Māori frameworks is vital for trust, safety, and equity.

Contemporary rangahau reinforces this worldview. Darrah et al. (2021) show that Māori experience disproportionate alcohol-related harm—an aftershock of colonisation where waipiro was used to alienate Māori from mana, whenua and whānau (Huckle et al., 2024). Together, these studies confirm that Māori alcohol harm reflects the enduring legacies of colonisation and inequitable regulation. Within hapūtanga, abstaining from alcohol can thus be understood as whakapapa guardianship—sovereignty over Te Whare Tangata that restores balance between wairua, tinana, whānau and whenua.

The same ethical lens must now turn to vaping, which has rapidly replaced smoking among young wāhine in Aotearoa. Early evidence suggested vaping might reduce harm for smokers, yet its safety in hapūtanga remains uncertain. Calder et al. (2021) found few studies and inconsistent outcomes; while one reported similar birth-weights for non-smokers and those who vaped, others showed potential fetal growth restriction. Ussher et al. (2024) confirmed that evidence quality remains low, and several studies link vaping to higher rates of preterm birth and low-birth-weight infants. Vallée et al. (2025) quantified this risk, identifying a 40% increase in preterm birth, 49% in low-birthweight, and 32% in small-for-gestational-age outcomes among mothers who vaped. Animal models reinforce these findings: Li et al. (2020) showed that replacing cigarette smoke with e-vapour in pregnant mice altered glucose and lipid metabolism, restoring some maternal markers but leaving offspring with persistent glucose intolerance and fatty-liver risk. These findings must be read against the PMMRC's most recent recommendations, which identify spontaneous preterm birth as a leading cause of perinatal death and call for national focus on its prevention and management (Public Health Communication Centre, 2024).

Sims (2025) adds that for young wāhine, vaping is not merely health behaviour but a social practice. Her study of tertiary students found that stress relief, body image, and peer belonging were strong motivators for vaping, with social media reinforcing its normalisation and appeal. Te Ngāngara – Limbic Capitalism in Aotearoa extends this analysis, showing that rangatahi Māori are deliberately targeted through algorithmic marketing that reframes consumption as identity and connection (Moewaka Barnes et al., 2024). Among 851 rangatahi Māori, 39% had seen vape advertising on social media, primarily on TikTok and Instagram. These industries, the authors argue, exploit the limbic brain — the emotional centre that governs craving and reward — to engineer dependency and extract profit from attention and breath (Moewaka Barnes et al., 2024). From a Māori worldview, this manipulation of desire breaches tapu: each

inhalation enters Te Whare Tangata, disturbing the breath of hauora and the rhythm of wairua. Protecting whakapapa therefore requires vigilance not only against colonial substances like waipiro but also against digital and corporate forces that commodify mauri and addiction under the guise of wellness and choice.

Innovation grounded in mātauranga Māori is already transforming maternal health practice. Salmon et al. (2025) describe the Heru and Hapū Māmā program — a smoking-cessation initiative for wāhine Māori built on traditional knowledge, whakawhanaungatanga, and digital connection. During COVID-19 restrictions, the program shifted entirely online, combining wānanga with videos, a Facebook support group, and an augmented-reality mobile app. Recruitment exceeded expectations (over 500 enquiries in under two weeks), retention was high (83%), and nearly half of participants reported quitting smoking by sixteeen weeks. Participants described wearing the carved heru — a taonga symbolising protection and ancestral connection — as a reminder of spiritual focus and maternal strength during hapūtanga. This kaupapa demonstrates how mātauranga Māori, technology, and collective support can re-centre te tapu o Te Whare Tangata within contemporary practice. The most effective cessation strategies are those that restore identity, belonging, and wairua — not merely focus on behaviour.

These ethics extend beyond humans. Lyver and Moller (2010) recount how elders of Tūhoe, Hauraki, and Rakiura tribes upheld the mana and mauri of birds as essential to collective wellbeing. The Kererū, a sacred kai for hapū wāhine, transferred its life force to the unborn child. When these observances were broken, the mauri between people and forest was severed—revealing tikanga as ecological law, an interspecies covenant of reciprocity and care.

Hapūtanga is a sacred continuum of development — a time when the tapu of creation is embodied within Te Whare Tangata, the vessel of life and lineage. Ko te whaea te takere o te waka — the mother is the hull of the canoe; she holds the generations together. Western science now mirrors this ancient knowing: the maternal body as the architecture of whakapapa, a living site of intergenerational exchange. Studies on Microchimerism reveal that during pregnancy, cells are exchanged bi-directionally between mother and child, embedding fragments of each within the other for life (Bianchi et al., 2021; Fjeldstad et al., 2020; Jacobsen et al., 2023; Peterson et al., 2013). These living cells have been identified in the heart, lungs, brain, and breast, where they contribute to tissue repair, healing, and immune regulation. Fjeldstad et al. (2020) describes this as a multigenerational continuum: a woman may carry cells from her mother and her children — each lineage continuing within the other.

From a Māori worldview, this phenomenon is not anomaly but affirmation — evidence of wairuatanga and whakapapa at work, the literal and spiritual weaving of generations. Cells forming part of neural and mammary tissues, contributing to lactation, thermoregulation, and emotional connection, reflect scientific echoes of aroha in motion. At times, imbalance in this exchange has been linked to pre-eclampsia, autoimmune conditions, or later-life cardiovascular illness, reminding us that health depends on tika, taurite, and mauri tau.

When I stand within Kapohanga-a-Rangi and look upon the photographs of whānau who have returned their kawe mate to her, I am reminded that this exchange of life is eternal. Their presence — both spiritual and cellular — draws us back to her, tracing unbroken lines of descent that live on in our flesh. Every breath, thought, and act of nourishment becomes part of that archive of embodied wisdom; every act of aroha sustains the pulse of our ancestry. Whether in birth or in loss, mother and child remain eternally bound — Te Whare Tangata as vessel and archive of whanaungatanga, carrying the echoes of all who came before and the promise of all yet to come.

Having traced the sacred continuum of hapūtanga, the next strand turns to Tūpuna Parenting (n.d.), the collective and intergenerational practice that sustains mauri once the child enters the world. Within tūpuna child-rearing, discipline was gentle and grounded in aroha, with humour and song serving as ancestral medicine. Angeli-Gordon (2025), in Taku Waipiataata, Taku Hei Tāwhiri, shows that these practices foster deep attachment, cultural identity, and spiritual security for tamariki and whānau.

Rameka et al. (2024) describe pre-colonial Māori parenting as egalitarian, interdependent, and grounded in collective responsibility. Wāhine and tāne shared nurturing roles, with fathers described by early observers such as Augustus Earle (1832) as “excessively fond of their children,” while wāhine led strategically as guardians of Te Whare Tangata. These accounts portray whānau life characterised by aroha, balance, and reciprocity — affirming that relational care, rather than hierarchy or domination, regulated whānau life in Māori society.

Wehi et al. (2023) illustrate the endurance of tikanga through the poukai — gatherings where manaakitanga and kaitiakitanga are enacted in the preparation, sharing, and stewardship of kai. At these events, feeding the people becomes both ceremony and care, strengthening relationships among whānau, whenua, and kai. Such practices embody intergenerational reciprocity and environmental responsibility, sustaining wellbeing through collective action. Together these insights affirm that Tūpuna parenting (n.d.), and whānau-based care are grounded in the same principles of relationship and balance that underpin Māori frameworks for hauora and whānau ora.

If Tapu Whilst Hapū protects conception and gestation and Tūpuna Parenting (n.d.), nurtures parenting practice, then Te Aho Matua extends that care into education. As discussed in Chapter Two, Te Aho Matua situates conception within a cosmological continuum where wairua and tinana unite through the iho matua — the spiritual umbilicus linking each child to Io Matua Kore. It teaches that learning, parenting, and midwifery are one raranga — interwoven acts of spiritual discipline and knowledge. The six sections of Te Aho Matua mirror the dimensions of Te Wheke — wairua, hinengaro, tinana, taiao, whatumanawa, and whanaungatanga — affirming that education is the lifelong unfolding of whakapapa and the nurturing of mauri.

Rangahau in early childhood education, including Nuri (2024) and McMillan (2024), confirms that culturally grounded learning from the earliest years shapes lifelong engagement, identity, and wellbeing. Nuri (2024) found that whānau in low-socioeconomic communities value te reo, tikanga, and intergenerational teaching as the true foundations of achievement. McMillan (2024) describes kōhanga reo as the seedbed of Māori educational success, where reo, wairua, and whānau intertwine like the rito and awhi rito of the harakeke. Together, their findings show that education grounded in whakapapa and collective wellbeing empowers learners and strengthens whānau across generations.

Tomlins-Jahnke (2025) shows that Māori students in kura kaupapa achieve high academic outcomes while maintaining fluent reo and deep whakapapa connections. When learning is structured through wairuatanga, whanaungatanga, and manaakitanga, education becomes a vehicle for sovereignty and cultural self-determination rather than assimilation. Hughes et al. (2025) adds that Indigenous families define educational success through wellbeing and contribution — the ability to live well, care for family, and strengthen community. This holistic view locates learning within whānau ora, affirming education as a pathway to collective stability and intergenerational flourishing.

Escott and Abraham (2025) extend the framework first articulated by Webber and Macfarlane (2020) in Mana Tangata: The Five Optimal Cultural Conditions for Māori Student Success, identifying that five interconnected expressions of mana — mana tangatarua, mana tū, mana motuhake, mana ūkaipō, and mana whānau — form the optimal cultural conditions for Māori success. Each links achievement to belonging and wellbeing, showing how Kaupapa Māori education restores mana and nurtures confident, culturally grounded adults and parents.

Strengthening Māori representation in health and education is the practical continuation of this kaupapa. Tupara and Tahere (2020) revealed that Māori midwifery students experience the highest attrition and lowest completion rates across tertiary education, largely due to racism, isolation, and the absence of Māori mentorship. The report advocates for a Māori-led

midwifery school grounded in Tūranga Kaupapa and Te Tiriti o Waitangi principles, noting that when culturally grounded mentoring was introduced, student retention and success increased dramatically.

Encouragingly, initiatives such as Te Ara o Hine–Tapu Ora demonstrate the transformative potential of targeted, Kaupapa Māori support in Midwifery schools, providing pastoral, academic and financial support for Māori and Pasifika students (Martin, 2021). Established in 2021 the programme has already produced record results, in 2025, the Ara Institute of Canterbury celebrated its largest-ever cohort of Māori and Pasifika midwifery graduates (Armah, 2025). These outcomes show that when Māori midwives are supported through relational, well-resourced pathways, the ripple effects extend beyond individual achievement to collective health equity.

Bonner et al. (2025) identified that across thirty-three universities in Australia and Aotearoa New Zealand, only fifty-five Aboriginal, Torres Strait Islander, and Māori nursing and midwifery academics were employed—most at lecturer level—and that neither country has reached parity with its Indigenous population. The authors call for Māori-led succession planning, mentoring, and professional development to ensure Indigenous educators can shape curricula and rangahau from within, securing enduring equity in representation and influence

Pihema et al. (2023) show that Māori midwifery mentoring functions as a decolonising and wairua-centred practice. Through tuakana-teina relationships grounded in tika, pono, whakawhanaungatanga, and kai-sharing, mentors help mentees navigate colonial systems while remaining grounded in te ao Māori, sustaining both parties and enabling Māori midwives to stay within the profession without compromising identity—truly “filling the kete.”

Across these layers of practice—from kōhanga reo to kura kaupapa, from tertiary training to mentorship—Kaupapa Māori education and support already provide a complete, wairua-centred foundation for learning and leadership. It nurtures confident, culturally grounded practitioners who embody mana and whanaungatanga in every domain. To realise whānau ora systemically, Aotearoa’s institutions must re-align with this ancestral infrastructure with flexibility to offer hybrid options for hauora: clinics should feel like marae, schools like whānau, and universities like whāriki woven of wairua and tikanga. Culture is infrastructure — its true measure is warmth, belonging, and spiritual safety, the foundations of hauora across generations.

This discussion has shown that Māori philosophy and practice operate as a living system of health—expanding seamlessly from ancestral ceremony to contemporary care. From Tapu Whilst Hapū to Tūpuna Parenting and Te Aho Matua, the same spiritual and ecological logics persist: what enters, exits, and circulates through the body and the world shapes generations.

Alcohol, vaping, and the algorithmic colonisation of desire reveal how external forces can fracture these relationships, turning consumption into disconnection. Yet Māori-led innovations such as Heru and Hapū Māmā, kaupapa-based education, and the restoration of whakawhanaungatanga show that healing endures when wairua leads design. Whānau ora therefore emerges not as program or outcome but as philosophy—an intergenerational commitment to balance, Mana wāhine, and tikanga as the infrastructure of life. When whakapapa is protected in body, learning, and environment, Aotearoa's systems too can breathe in rhythm with te ao Māori.

These intergenerational teachings—from Tapu Whilst Hapū to Tūpuna Parenting and Te Aho Matua—demonstrate how wairua is transmitted through everyday practice. Having traced these whānau-centred continuities, the next section turns outward to the wider system, exploring how the principle of wairuatanga can inform policy, leadership, and workforce design.

5.4 Wairuatanga | The practice of remembering whakapapa.

This discussion builds upon the previous section by extending Māori philosophy into the structural design of maternity and health systems. It examines how wairuatanga functions as the guiding principle through which policy, leadership, education, and practice can restore whakapapa and balance within Aotearoa's maternal-infant care.

Wairuatanga is the compass of creation. It teaches that every act of making—whether building a whare, raising a child, or reforming a system—must begin in whakapapa and remember the lines from which it descends. To live and work through wairuatanga is to recognise that all structures, physical or institutional, are living bodies that must breathe in rhythm with the whole. In maternity and health this means seeing the māmā, whānau, midwife, and system as one organism, each dependent on the flow of mauri and reciprocity between parts. Wairuatanga is therefore not an abstract spirituality but a framework of governance, balance, and aroha. This framework answers the wero raised in Te mokemoke o te wairua, where whānau described hospitals as spiritually barren and yearned for care that recognised Te Whare Tangata as a sacred site.

As Henry (2015) describes, te whare ako — the house of learning — embodies this relational architecture. It is both a physical and metaphysical space that speaks to manawa, hinengaro, and wairua, shaping how knowledge is taught, received, and lived. In the same way, maternity systems grounded in Kaupapa Māori must act as living houses of learning, spaces where wairua and wisdom are woven through daily practice, translating spiritual ethics into lived care.

Practicing wairuatanga professionally requires reflection across worlds. It calls us to hold Indigenous hauora paradigms alongside biomedical models, discerning the gold standards of practce that emerge where these philosophies meet. It also demands ethical boundaries and deep self-knowledge: when the māmā is fed, the child is fed; when the ahi kā burns steady, the people thrive. In this worldview, every lever of the health system must carry mauri; philosophy must become form.

Embedding wairuatanga across maternity and early-years care begins with how resources flow. Finance itself must carry whakapapa. A ring-fenced Maternity and Early Years Fund, jointly governed by iwi and the National Public Health Service [NPHS], would ensure that every dollar follows the māmā and whānau, not the contract. Quarterly public reporting and equity loadings for rural and high-need regions would restore transparency and justice to resource allocation, while reinvestment in marae-based clinics, ūkaipō and lactation initiatives, perinatal mental-health and rongoā services, and professional development cover for clinicians would turn finance into an act of whanaungatanga. This shift aligns with wellbeing-budget philosophies that move beyond output-driven economics; Moll et al. (2025) describe such budgets as centring participation, social justice, and intergenerational equity—a Kaupapa Māori maternity fund would embody that change.

Time, too, is a spiritual resource. It is the most undervalued currency in healthcare and yet the one that most directly protects wairua. Safe staffing ratios that reflect complexity rather than averages—one midwife to six patients, including the pēpi, as a patient—would protect the relational minute where karakia is spoken, stories are shared, and anxiety is eased before it becomes illness (Queensland Nurses and Midwives' Union [QNMU], 2025; WHO, 2024). In this context, time is not an expense but a clinical instrument measuring compassion and connection.

Leadership must also breathe wairua and be accountable to whakapapa. Each region requires a Maternal and Infant Wellbeing Lead, jointly appointed by iwi and the NPHS, to bridge hospital and community and to ensure that policy reflects lived experience. Recent restructuring within Health New Zealand, including the proposed restructuring and downsize of Kahu Taurima – Maternity and Early Years department, revealed how fragile Kaupapa Māori leadership becomes when it is not protected in law (Thomas, 2025). Clifford and Lawrie (2024) called these cuts "the unkindest of all," and the Public Service Association (2024) warned that removing Māori and Pasifika roles would deepen inequity. Such events affirm that Kaupapa Māori leadership must be statutory and enduring, grounded in whakapapa rather than political goodwill.

Comparative Indigenous evidence supports this shift toward legally protected Indigenous governance and education. Research from Canada and Australia demonstrates that when Indigenous leadership and curriculum sovereignty are legislated, health and education systems become structurally accountable to self-determination (Barnabe, 2021; Turpel-Lafond & Johnson, 2021; Leblanc et al., 2025; Judd & Roy, 2025).

Information, likewise, must act as relationship rather than record. A live, bilingual National Maternity Directory embedded in clinical systems and printable for rural use could map hapūtanga wānanga, Rongoā practitioners – who are ACC accredited and hold maternal birth injury contracts, lactation and mental-health supports, transport, and kai assistance. When information travels with whānau, continuity of care plan and recovery becomes natural; data becomes another dialect of whakapapa, tracing the relational threads that sustain wellbeing.

Wairuatanga also transforms how we understand workforce wellbeing. A Kaupapa Māori model builds schedules around collective rhythm rather than institutional rosters. Midwives, Kaiawhina, Rongoā practitioners, lactation consultants, and whānau ora coaches share responsibility, supported by paid supervision—clinical, cultural, and peer—so that those who care are also cared for. This design honours the principle that exhaustion is a spiritual injury. Rangahau confirms that collective support and rest protect both staff and whānau; rotating night shifts and chronic fatigue are linked to infertility and psychological distress (Moćkun-Pietrzak et al., 2022). Protecting midwives' wairua is therefore protecting maternal health itself. As voiced by participants in Te Whare Pora o Hine-te-Iwaiwa, when midwives practice through wairua and whakapapa, birthing becomes ceremony — restoring safety and tino rangatiratanga for whānau.

Education must also grow from the land. Māori-authored curricula, Kaupapa-Māori placements, and postgraduate pathways in supervision, developmental care, and leadership will cultivate practitioners grounded in wairuatanga. Immersive iwi-based learning—the most effective route to cultural safety (Capper et al., 2023)—should be standard, while a Māori Midwifery School modelled on the Indigenous competency framework of National Aboriginal Council of Midwives [NACM] (2019) would formalise Māori authority over maternity education, workforce accredited providers, evidence-based rangahau, which supports policy and indigenous practices. Formalising tuakana-teina mentoring programs ensures that cultural safety is modelled as practice, not paperwork – and there are other NZQA accredited pathways within Midwifery.

Evaluation, too, must reflect wairua. Systems often count procedures, but whānau count experience. Indicators defined by wahine and whānau—warmth, belonging, consent, continuity, and spiritual safety—should stand beside biomedical metrics. Environmental audits

of light, sound, and rest; documentation of karakia, skin-to-skin, and whānau presence; and staff-wellbeing surveys would reveal whether care upholds or erodes tapu. In this way, data becomes a living whakapapa map, showing how aroha moves through the system.

Even design itself can remember whakapapa. Clinical environments can embody pūrākau, turning architecture into prayer. A Tangaroa-themed neonatal unit, inspired by the pūrākau of Māui-tikitiki-a-Taranga—born prematurely and sustained by Tangaroa—could translate cosmology into healing practice: oceanic hues, dimmable womb-like light, taonga pūoro soundscapes, and whānau presence as co-regulators, with mauri-balance audits linking sensory environment to physiological stability. This is not metaphor but Indigenous method: a Kaupapa Māori blueprint for spaces that heal through harmony.

Across every lever—finance, time, leadership, information, workforce, education, measurement, and environment—the same truth endures aroha is infrastructure. A maternity system built on wairua, and whakapapa achieves safety not through surveillance but through relationships. When midwives are rested, whānau included, and environments honour atua, Aotearoa realises the wellbeing economy envisioned by Moll et al. (2025): a nation where success is measured not by output, but by the flourishing of life itself.

Yet, to uphold wairuatanga within systems, we must also uphold it between ourselves. The professional development of the midwife is not only clinical growth but spiritual discipline. Each practitioner who rises to strengthen Kaupapa Māori midwifery contributes to the collective ascent of mātauranga Māori. To criticise, compete, or diminish those carving new pathways is to fray the very whāriki we claim to protect. As the literature in Chapter Four showed, symbolic violence and internalised colonial hierarchies deplete wairua and distort kaupapa (Thapar-Björkert et al., 2016; Johnston, 2005). He toa takitini, kāore he toa takitahi — it is through the courage of many, not the isolation of one, that transformation endures. Professional reflection therefore includes learning to uplift others, to see their work as extensions of our own lineage, and to celebrate the plurality of hands weaving this whāriki. When we support rather than silence each other, we strengthen the ethical and spiritual foundations of our profession and model the very care we seek to restore in maternity services.

Ultimately, the wairuatanga of Te Whare Tangata, is the sacred consciousness of creation—the meeting of tinana, wairua, and whakapapa. Western research calls this empathy and spiritual presence (Moloney & Gair, 2015; Crowther & Hall, 2015), yet within te ao Māori it is ancestral law moving through Te Whare Tangata. When midwives practice with empathy, intuition, and reverence, they open the portal where atua and ancestry meet, ensuring that pēpi enter the world with intact wairua. To exclude this dimension is to sever whakapapa; to uphold it is to protect the continuum of life.

Through karakia, pure, oriori, te reo, karanga, whenua-ki-te-whenua, manaakitanga, waiata, pūrākau, and kai, midwives embody the tikanga of their whakapapa. They fill their kete with ancestral teachings—Te Aho Matua, Tūpuna parenting, karanga, hue, raranga—and support births with rongoā, muka, ūkāipō, and romiromi. In doing so, they elevate the mana of whānau and ensure that every birth reaffirms the sanctity of Te Whare Tangata and the unbroken flow of life. The following recommendations translate these philosophies into tangible reforms, informed by international precedents that demonstrate how Indigenous governance, education, and workforce wellbeing can be structurally embedded within national systems.

5.5 Whakahoki ki ngā pātai: Returning to the rangahau questions.

This section draws the threads of the whāriki together by returning to the five pātai that guided this rangahau. Each question stands as a pou within the whare of wairuatanga, tikanga, and whānau ora—marking the movement from disruption to restoration, from loss to reclamation. Revisiting these pātai consolidates the thesis findings and reveals how Kaupapa Māori philosophy, Indigenous midwifery, and whānau ora practice converge as a living framework for maternity transformation in Aotearoa.

First, on wairuatanga: this study confirms that wairua is not a metaphor for spirituality but the living architecture of Māori health and education. Across Chapters Two through to Five, evidence shows that when wairua is centred—through karakia, oriori, mirimiri, or relational presence—healing deepens, trust strengthens, and clinical outcomes improve. Midwifery models that honour the spiritual dimensions of birth, such as those described by McNeil et al. (2024) and McLardie-Hore et al. (2023), demonstrate measurable benefits for maternal and infant wellbeing. Wairuatanga therefore functions as the organising intelligence of care: the balance point between connection, accountability, and whakapapa.

Second, on Te Tiriti: the findings affirm that health systems remain largely unaccountable to the partnership, protection, and participation promised in Te Tiriti. The dismantling of Māori equity teams, including Kahu Taurima (Thomas, 2025; Public Service Association [PSA], 2024), exposes how fragile these obligations become when they depend on political goodwill rather than constitutional protection. Yet pathways forward already exist—through iwi-led commissioning, Whānau Ora, and the Indigenous competency framework of NACM (2019)—all grounded in shared power, co-design, and intergenerational duty. Te Tiriti is not a relic; it is a living covenant that must be structurally honoured in maternity governance, funding, and accountability.

Third, colonisation and reclamation: the rangahau reveals that colonisation did more than impose biomedical systems; it fractured the spiritual and constitutional authority of wāhine Māori over Te Whare Tangata. Reclamation begins where policy meets whakapapa. The

resurgence of Kaupapa Māori birthing knowledge, Tūpuna parenting, Kōhanga Reo, and Kura Kaupapa Māori shows that cultural revitalisation is itself a public-health intervention. Every karakia, every wānanga, every whenua-return ceremony becomes an act of decolonisation—a re-weaving of the cord between atua and descendants.

Fourth, on Indigenous midwifery practice: this thesis affirms that Indigenous midwives carry both professional and cultural responsibilities. Their proximity to their own whānau is not a boundary risk but a foundation of safety, the point where clinical competence and spiritual guardianship converge. Protecting Indigenous midwifery therefore requires ring-fenced funding, iwi-co-governed education pathways, and trauma-informed tuakana–teina mentoring (NACM, 2019; Pihema et al., 2023; Tupara & Tahere, 2020). When Indigenous governance, mentorship, and ceremony are resourced, midwives can practice in ways that heal both body and spirit—transforming proximity into protection.

Finally, on whānau ora: the rangahau concludes that whānau ora is achieved not through programs but through relationships. It arises whenever wairua, whakapapa, and community are protected from fragmentation. Continuity of care, identified by Clapham & Eddy (2025) and WHO (2024) is the operational form of whānau ora, it builds systems where each encounter strengthens rather than isolates the collective. When every lever of policy, leadership, education, and time serves relationship instead of bureaucracy, equity becomes practice, not promise.

Together these five pātai reveal that Māori health sovereignty already lives within our everyday acts of care. The task ahead is not intervention but protection: to ensure that wairuatanga, whakapapa, and whānau remain the architects of maternity care in Aotearoa. When this covenant is upheld, every birth becomes a ceremony of remembrance, every birthing wāhine an atua, birthing a taonga tuku iho, every midwife a guardian of whakapapa, and every system an extension of the sacred continuum of life.

5.6 Ngā tūtohinga whakarāpopoto: Consolidated recommendations.

This section gathers the practical threads of this thesis into a single whāriki of reform. It translates the findings and philosophy of wairuatanga, whakapapa, and whānau ora into concrete system actions for Aotearoa's maternity and early-years care. Each recommendation arises from the evidence and voices woven through preceding chapters, ensuring that structural transformation remains faithful to the spiritual, relational, and constitutional foundations of Māori health.

The voices, evidence, and reflections woven through this thesis converge on one truth: the health of Aotearoa depends on the health of its mothers, and the health of mothers depends

on systems that honour wairua, whakapapa, and whānau. Reform must therefore begin not with a new policy but with a new philosophy—one that understands every act of maternity care as the weaving of a living whāriki connecting generations.

He pūtea tūturu | Funding that holds truth:

Finance must carry whakapapa: Funding should be ring-fenced through a Maternity and Early Years Fund governed jointly by iwi and the NPHS, ensuring that each dollar follows the whānau rather than bureaucratic contracts. Quarterly public reporting and equity loadings for rural or high-need regions would provide transparency and justice. Such accountability directs resources to the marae-based clinics, ūkaipō programmes, rongoā initiatives, and perinatal-mental-health supports where they are most needed (Mothers Matter, n.d.; Waitangi Tribunal, 2023a). Finance, when bound to whakapapa, becomes an act of relationship rather than transaction.

Maternity and early years Kaiawhina, Community Lactation Consultant services and Wellbeing-coach roles should be funded as integral, not peripheral, components of maternity teams. Midwives must also be properly recognised and renumerated for their specialist and or cultural expertise and qualifications. Research comparing midwives in Aotearoa and Australia found that New Zealand-trained midwives demonstrate higher autonomy, research capability, and professional competence than their Australian counterparts, and in Australia New Zealand trained midwives are regarded as overqualified and command higher salaries and leadership opportunities (Hildingsson et al., 2016). This inequity underscores the need for funding models that reflect the true value of midwifery as both a clinical and cultural profession. Fair pay, postgraduate qualification recognition, and parity with international remuneration standards are acts of justice that honour the mauri of the workforce and sustain the whakapapa of care.

Te taha mana o te Hauora | The power dimension of health:

Equity cannot survive as an optional program. The downsizing of Kahu Taurima and other Māori equity teams (Clifford & Lawrie, 2024; PSA, 2024; Thomas, 2025) demonstrates the fragility of kaupapa when leadership rests on political tides. A regional network of Maternal and Infant Wellbeing Leads, jointly appointed by iwi and the National Public Health Service, would anchor decision-making in whakapapa and ensure Māori voices shape design, funding, and evaluation. This structure transforms leadership from compliance to covenant.

The Maternal Quality & Safety Program remains hospital-dominated, with minimal structural inclusion of community and Kaupapa Māori providers. Even where Māori or non-government organisation representatives contribute, they do so as individual invitees rather than as co-governors or funded partners. Leadership therefore continues to centre on secondary or

tertiary institutions rather than whānau-based care networks. The National Maternity Monitoring Group [NMMG] (2019) affirmed that Māori-led, bicultural frameworks must sit at the centre of system design, not the periphery. Māori consumer representatives within the NMMG called for maternity leadership that embodies manaakitanga "not just at the service-provision level, but at a funding level," and for iwi to be trusted as holders of the solutions that best meet community health needs.

Current leadership structures, such as Directors of Midwifery—are largely positioned within Hospital and Specialist Services, a pattern reinforced by the membership of Maternity Quality & Safety Programs, which remain dominated by hospital clinicians and internal governance lines (Hauora Tairāwhiti, 2018; Health New Zealand 2023). Despite national maternity standards emphasising women-centred, community-based care (Ministry of Health, 2011; HQSC, 2019), structural co-governance with iwi, Kaupapa Māori, and community providers remains minimal.

The HQSC (2019) Maternal Morbidity Working Group and the National Maternity Monitoring Group (2019) both called for District Health Boards to partner with wāhine Māori and their whānau in the design and delivery of maternity services. Despite these directives, structural co-governance with iwi, Kaupapa Māori, and community providers remains limited. As both national groups concluded, Te Tiriti must not be treated as a principle of consultation but as a framework for shared authority.

Internationally, evidence shows that structural transformation is possible. In Canada, Barnabe (2021) demonstrates that Indigenous health equity depends on empowerment through self-determination—re-establishing community governance and embedding cultural approaches at the heart of health systems. The First Nations Health Authority in British Columbia illustrates how Indigenous-governed systems can reset health services around whānau, wellness, and locally defined priorities. Similarly, Turpel-Lafond and Johnson (2021) show that systemic racism in British Columbia's health system persists because Indigenous peoples are positioned as stakeholders rather than decision-makers. The In Plain Sight review, and the subsequent Declaration on the Rights of Indigenous Peoples Act (2019), provide a living model of accountability: embedding Indigenous leadership, anti-racism, and cultural humility into law and institutional practice.

Leblanc et al. (2025) extend this evidence through a case-based model of co-governance between universities and First Nations health authorities, showing that authentic transformation requires legal partnerships, shared decision-making, and Indigenous control of intellectual property. Judd and Roy (2025) likewise contend that true reform demands First Nations leadership "at the heart of the tertiary education system," advancing self-

determination through sustained investment in Indigenous led rangahau and governance. Together, these frameworks affirm that transformation begins when systems move beyond cultural-safety training to structural redistribution of power—when allyship becomes architecture.

These patterns of control and surveillance are not new. They echo the colonial hierarchies that once criminalised Indigenous knowledge and persecuted wāhine healers as witches. The punitive cultures that persist in contemporary health governance—where scrutiny replaces support and compliance overshadows compassion—are behaviours we have learnt through observing, participating in, and being victim to centuries of witch hunts. To dismantle these inherited patterns requires courageous leadership grounded in aroha, equity, and wairua — leadership that names historical violence and refuses to replicate it in modern institutional form.

To achieve coherence across Aotearoa's maternity and early-years system, leadership must extend beyond hospital walls. A network of NPHS and Maternal and Early Years Leads, jointly appointed by iwi and the NPHS, should operate across disciplines, regions, and providers. Anchored in Kaupapa Māori governance, these roles would complement—not duplicate—hospital leadership, bridging community midwifery, public health, and iwi-led initiatives. Such a structure would transform leadership from compliance to covenant, embedding accountability to iwi, wāhine, and pēpi as a living expression of Te Tiriti and the collective pursuit of equity as everyday practice.

Time is care: Safe-staffing ratios — such as the one midwife to six patients model trialed in Queensland, Australia — must be legislated to protect the relational care where wairua work occurs. These ratios embody the relationship-based, compassionate care principles championed by the World Health Organization (2024), which recognises midwifery models of care as person-centred, respectful, and essential to maternal and infant wellbeing (Queensland Health, 2024; QNMU, 2025; WHO, 2024). Continuity of care is not a luxury but a Te Tiriti-level obligation: evidence confirms that consistent midwifery relationships reduce pre-term birth, improve breastfeeding outcomes, and restore trust and safety for wāhine and whānau (Corcoran et al, 2017; McNeil et al., 2024).

Whāngaihia te wairua o te kaimahi | Nurturing the health workforce:

Workforce must be sustained through valued aroha: Paid supervision—clinical, cultural, and peer—must be embedded in workloads so reflection and recovery become professional norms. Reflective supervision, as described by Rankine & Thompson (2021), shifts supervision from surveillance to collective learning, strengthening wellbeing, accountability, and cultural safety across teams. Māori midwives require wrap-around mentorship and

protected wairua time to prevent burnout (Tupara & Tahere, 2020; Pihema et al., 2023). Kaiawhina and whānau-coach roles should be funded as integral, not peripheral, components of maternity teams.

Leblanc et al. (2025) show how aroha-centred mentorship sustains practitioners through Elder-led education, protected cultural supervision, and legally recognised intellectual-property agreements. This model of ethical reciprocity parallels Kaupapa Māori mentoring, where aroha and accountability flow intergenerationally. Judd and Roy (2025) add that strengthening Indigenous rangahau and academic pipelines require exactly such relational structures—cohort mentoring, safe spaces, and leadership programs that build belonging and confidence. Both affirm that Indigenous wellbeing in professional life depends on collective care, not individual endurance.

These findings highlight the importance of how learning spaces are held. When reflection is shaped through aroha and collective accountability, practitioners grow; when supervision becomes surveillance, wairua is diminished. This distinction is acutely felt in professional settings such as Perinatal Mortality and Morbidity Review meetings, which often carry a punitive tone. Research shows that such forums frequently individualise blame rather than examining systemic causes — a dynamic that silences wairua, discourages learning, and reproduces colonial hierarchies within clinical governance (Willcox et al., 2023).

When the process centres on error and individual blame rather than system learning, midwives disengage, and collective insight is lost. This pattern reflects a colonial inheritance—a culture of scrutiny and punishment rooted in the persecution of women healers during the European witch hunts and later echoed in Aotearoa through the Tohunga Suppression Act 1907. Both sought to regulate knowledge, silence spiritual authority, and replace communal accountability with institutional control. The same impulse endures when reflective spaces become sites of fear rather than learning.

Generations of wāhine have learnt, through observation and experience, that visibility in such environments can invite judgment and harm. True reflective supervision must therefore foster psychological and spiritual safety, recognising that mistakes often reveal the limits of system design and workforce restriction rather than personal failure. When spaces of review are guided by compassion, transparency, and shared responsibility, they become sites of restoration rather than re-traumatisation.

The need for such transformation extends beyond midwifery. The nationwide industrial actions ultimately manifested on 23rd October 2025—as discussed in Chapter Two—demonstrated that the crisis of care is collective, not isolated. The strike made visible a workforce whose wairua has been eroded by structural neglect and undervaluation. These movements serve

as a contemporary karanga for renewal: a reminder that sustaining the workforce requires more than fiscal reform—it demands the restoration of mauri through care, reflection, and cultural safety. Paid supervision, mentorship, and protected wairua time are therefore not privileges but essential acts of justice.

Tuakana–teina mentoring must be formalised so cultural safety is lived, not performed, and measurable outcomes are evaluated accordingly. Recent evidence from the Wāhine Connect program demonstrates that structured mentorship significantly enhances wellbeing and career confidence for women in health, confirming the ongoing need for system-supported mentoring frameworks (Grainger et al., 2025). Combined with Indigenous frameworks of aroha and whanaungatanga, supervision becomes restorative practice: nurturing the mauri of those who care for others. Protecting Indigenous midwifery practice means safeguarding the proximity between healer and community as a professional strength, not a liability.

Whakapapa mātauranga ki te whenua me te wairua | Grounding education in land and spirit:

Education must grow from the land: Māori-authored curricula, Kaupapa-Māori placements, and postgraduate pathways in supervision, developmental care, and public-health leadership will nurture practitioners grounded in wairuatanga, in a variety of settings. Immersive iwi-based learning is shown by Capper et al. (2023) to be the most effective route to cultural safety and should be part of standard education and professional development. A Māori Midwifery Curriculum informed first and foremost by the principles of Te Aho Matua would ensure that learning, practice, and leadership emerge from Māori cosmology, language, and whakapapa. Grounded in this foundation, a Māori Midwifery School could draw from other Indigenous frameworks such as the NACM (2019), formalising Māori authority through shared Indigenous precedent while remaining distinctly guided by atua Hine-te-Iwaiwa. In this way, education becomes a continuation of ancestral teaching rather than an adaptation of external standards—restoring wairua, tikanga, and whakapapa as the governing principles of midwifery knowledge and practice – rather than reproducing tokenistic representations of Māori within institutional spaces.

Leblanc et al. (2025) situate decolonising education as a human-rights imperative under Article twenty-four of the UNDRIP, which guarantees the right to “the highest attainable standard of physical and mental health.” They show how universities can uphold this right through community-governed partnerships that embed Elder-led teaching, protect Indigenous intellectual property, and ensure accountability to the peoples whose lands they occupy. Their tripartite governance model—uniting a First Nation, a tribal health authority, and a medical university—demonstrates how culturally competent education can be built through legal partnership and shared power.

Judd and Roy (2025) extend this principle through the Universities Accord, calling for First Nations leadership to sit “at the heart of the tertiary education system.” They argue that self-determination and sustained investment in Indigenous led rangahau are essential to closing equity gaps and realising the full potential of Indigenous knowledge systems. Their analysis reframes universities not as owners of knowledge but as partners in its stewardship—an ethos mirrored in Kaupapa Māori education, where knowledge is relational, land-based, and collectively held.

Ahuriri-Driscoll et al. (2021) identify this shift as the rise of Indigenous sovereign leadership within public-health education: a movement that decolonises curriculum design, pedagogy, and assessment so that wairua and relational accountability become central learning outcomes. Rasmus et al. (2020) describe a parallel evolution in Indigenous rangahau ethics, calling for “sustainability-before-scalability”—building local capacity and governance before expansion. Together these frameworks articulate a consistent global message: that equity, cultural competence, and excellence are achieved only when Indigenous peoples govern the systems that educate their own healers.

Training should form a seamless whakapapa of learning: certificate, diploma, bachelor’s, postgraduate diploma, master’s, and doctoral pathways that allow natural progression into midwifery and related specialisations. Pathways in wāhine, infant and whānau nutrition, fertility, contraception, abortion care, maternal mental health, hormonal regulation, and reproductive wellbeing, rongoā and naturopathy for wāhine, would build a diverse workforce of Māori maternal and infant wellbeing health specialists whose scope reflects the realities of whānau life and natural progressions. Each qualification and service should be claimable under a unified funding system, recognising that holistic women’s health—from conception to menopause—is one continuous continuum of care grounded in whenua and wairua.

In this way, Māori midwifery education becomes both local and global in its vision: grounded in whenua yet resonant with Indigenous movements worldwide. Education that grows from the land honours atua, protects whakapapa, and sustains those who carry the ancestral mandate to safeguard Te Whare Tangata.

Whakaata i te mauri | Reflecting the life force:

Measurement must reflect wairua: Evaluation systems should privilege indicators defined by wāhine and whānau—warmth, belonging, spiritual safety, consent, and continuity—alongside biomedical metrics. Frameworks such as Te Hā o Whānau (Stevenson et al., 2020) and the Meihana Model (Matenga & Westenra, 2022), provide relational and clinical scaffolds for measuring quality in ways that centre wairua and whakapapa. The Meihana Model extends Te Whare Tapa Whā through its Waka Hourua design, emphasising the interconnected

dimensions of tinana, hinengaro, wairua, taiao, and iwi katoa, while recognising how the crosswinds of colonisation, racism, migration, and marginalisation disrupt balance. Together these tools affirm that aroha and relationship are legitimate determinants of health. Incorporating environmental audits, documentation of karakia and skin-to-skin, and staff-wellbeing reviews would ensure that data speaks the language of wairuatanga.

He whare whakapapa | The genealogy of space:

From the design of birthing spaces to the frameworks that regulate them, infrastructure must embody wairua. The built environment is never neutral—it breathes the values, genealogies, and spiritual assumptions of those who shape it. Within a Kaupapa Māori worldview, buildings are living entities that hold mauri and whakapapa; the architecture of birth must therefore reflect the balance between atua, whenua, and the sacred interior of Te Whare Tangata. When space aligns with cosmic order—its light, temperature, sound, and flow moving in rhythm with the universe—it restores equilibrium and nourishes both body and spirit.

Evidence affirms this Indigenous knowing. O'Callaghan et al. (2019) demonstrate that single-family neonatal rooms improve sleep, breastfeeding, infection control, and parental wellbeing. Nicoletta et al. (2022) show that calm, flexible, midwife-led spaces promote autonomy and intimacy, proving that architecture itself can enhance the work of a midwife to promote positive wellbeing. In Aotearoa, Adcock et al. (2023) found that neonatal "champions" who honour aroha, karakia, and whanaungatanga create sacred space within biomedical systems—reasserting wairua as the foundation of safe care.

Ocean-inspired neonatal environments, maramataka-aligned scheduling, and rongoā integration illustrate how Indigenous cosmology can inform clinical excellence. The pūrākau of Māui—born prematurely and nurtured by Tangaroa—reminds us that even our tiniest patients are sustained by the rhythmic intelligence of the natural world, held within tides of balance, breath and renewal. When built environments are conceived through relationship with atua, they become active participants in healing, regulating physiology and emotion while restoring harmony between the physical and spiritual realms. Through such design, birth is returned to ceremony; each space becomes a living vessel of whakapapa, carrying the pulse of creation into modern medicine.

Together, these insights form a single proposition: Wairuatanga is the architecture of sustainable maternity care. A system grounded in whakapapa ensures that finance, time, leadership, workforce, education, and evaluation are not separate policies but interwoven threads of one whāriki. When each strand is held taut by accountability to iwi, wāhine, and our mokopuna, Aotearoa will no longer speak of equity as aspiration but live it as everyday practice.

5.7: Limitations and future rangahau.

Every whāriki has its outer edge. This rangahau has been woven through Kaupapa Māori methodology, guided by wairua, whakapapa, and lived experience within maternity practice. Its strength lies in depth rather than breadth, privileging cultural integrity and relational validity over generalisation. The findings therefore speak as situated truths—threads drawn from Māori midwives, whānau, and Indigenous scholarship that illuminate what wairua-centred care can look like in Aotearoa.

While grounded in lived experience, I acknowledge my language fluency is still evolving – a legacy of colonisation embodied in my whānau pūrākau of being caned for speaking te reo at school. Rather than a deficit, I hold this as a site of intergenerational healing — restoring the voices and cosmologies that colonisation sought to silence (Shandley, 2022).

As an insider researcher, I was seen through multiple lenses – a researcher, midwife, whānau member, and leader. This visibility brought both privilege and scrutiny, requiring balance between community accountability and self-perseverance. I carried the awareness that how I conducted myself – not only as a scholar but as a person – reflected on the kaupapa and on those who entrusted me with their stories.

Life realities and temporal constraints:

Balancing full-time work, whānau responsibilities, and postgraduate study inevitably created time constraints. Periods of burnout and personal challenge required extensions and intentional rest. During data transcription, my whānau navigated the tangihanga of a close whānau member, to which the responsibility to host this sacred ceremony, fell upon my husband and me — moments where grief and scholarship coexisted.

Rather than weakening the process, these realities grounded the thesis in the lived textures of Māori life: birth, death, work, and healing co-occurring in the same breath. This reminded me that Kaupapa Māori rangahau is not performed outside of life but through it — the whāriki is woven in real time, between housework, employment, parenting, academic deadlines and karakia.

These intersections strengthened my understanding of balance, resilience and relational accountability – showing that when rangahau is guided by wairua and sustained by whānau, the process itself becomes a form of healing, restoring focus and motivation – to keep moving forward.

Given these commitments, some avenues may not have been explored as deeply as intended, and analytical choices were shaped by the need to remain within word limits. Through multiple rounds of refinement, I have reminded myself that what is presented here is enough – that it

carries integrity and purpose in its current form. This acknowledgement is itself an enactment of Mana wāhine, recognising both the struggle and strength of holding multiple roles while remaining steadfast to the kaupapa.

Scope and Context:

This study was completed during a period of major structural reform in Aotearoa's health system. The proposed disestablishment of Kahu Taurima – Maternity and Early Years and other Māori equity teams (Thomas, 2025; PSA, 2024), along with the disbanding of Te Aka Whai Ora under the Pae Ora Amendment Act 2024, exposed the fragility of Kaupapa Māori infrastructure (Came et al., 2024; Waitangi Tribunal, 2024), and heightened the urgency of this rangahau. These reforms limited access to consistent national evaluation data and highlighted the need for long-term Kaupapa Māori evaluation studies to trace outcomes before and after system transformation.

Data and Participation:

This thesis intentionally privileged Māori-authored and Indigenous-led literature to uphold epistemic sovereignty. That decision narrowed the analytic lens but preserved the cultural and spiritual accountability central to Kaupapa Māori rangahau. Further mixed-methods and quantitative studies are now needed to extend these findings—linking kaupapa principles with measurable improvements in perinatal health, workforce retention, and cost efficiency. Future work should also broaden participation to include urban, whaikaha, migrant, and rainbow members of our whānau, whose maternity experiences remain under-documented yet are essential to a holistic national picture of equity.

Translation and Implementation:

The reforms outlined in Chapter Five are intentionally ambitious, describing a whānau-centred system architecture grounded in wairuatanga, whanaungatanga, and manaakitanga. Implementing these ideas will require enduring political commitment, legislative protection, and cross-sector collaboration. Pilot sites and Kaupapa-Māori evaluation frameworks should accompany each reform stage—testing feasibility, resourcing, and outcomes in real time. This translational phase will determine how the theoretical architecture of Te Whāriki o Hine-te-Iwaiwa performs in practice, ensuring its mauri remains intact as it moves from vision to implementation.

Researcher Positionality:

As both researcher and midwife, I stand within the kaupapa I describe. This insider position enriches interpretation but demands constant reflexivity to balance personal insight with collective evidence. Triangulation through wānanga, peer feedback, and alignment with national data strengthened analytic credibility; nevertheless, my worldview remains visible in

the weave. In Kaupapa Māori rangahau, such visibility is not bias but whakapapa—an ethical accountability to those whose stories are carried here.

Future rangahau directions: Future inquiry must be collaborative, intergenerational, and translational rangahau that moves from page to birthing room. Key priorities include:

- Evaluating the outcomes of Māori-led maternity reforms across clinical, cultural, and economic dimensions;
- Developing metrics of wairua, mauri, and relational safety for integration into national health quality systems;
- Examining the effectiveness of Kaupapa-Māori education pipelines in growing and sustaining the Indigenous midwifery workforce;
- Exploring intersections between epigenetics, intergenerational trauma, and spiritual imprinting, bridging mātauranga Māori and molecular science.

These directions already align with national kaupapa. Te Aukume a Hine-te-Iwaiwa, the Māori-led rangahau collective, has articulated these very priorities through the ON TRACK Network (2023) wānanga. Their agenda calls for studies that strengthen Māori midwifery leadership, integrate rongoā and Kaupapa Māori practice, rongoā, advance perinatal mental-health and suicide-prevention rangahau, and build intergenerational rangahau capability. The reforms proposed in this thesis provide an operational pathway for that agenda.

Parallel alignment is found in the Women's Health Strategy 2023, which identifies wāhine and whānau wellbeing as national priorities and reaffirms the Crown's obligation to protect the Indigenous rights of wāhine Māori to exercise tino rangatiratanga and mana motuhake over their health (Ministry of Health, 2023b). Integrating Kaupapa Māori rangahau with these national strategies will ensure that future maternity scholarship remains Tiriti-anchored, globally relevant, and spiritually grounded.

In essence, the future of this work is not only academic but ancestral. It belongs to the next generation of midwives, researchers, and whānau who will continue to weave Te Whāriki o Hine-te-Iwaiwa in new contexts. Their task will not be to start again, but to strengthen the threads—to test, translate, and extend the kaupapa so that its mauri continues to pulsate through every birth, every policy, and every act of care in Aotearoa.

5.8 Ko te otinga: Returning to the source.

When this thesis began, it entered Te Whare Pora to learn the art of weaving whakapapa, now I emerge carrying Te Whāriki o Hine-te-Iwaiwa, held aloft, it's become a cloak for Aotearoa's maternity system — woven from wairua, equity, tikanga, and aroha. In lifting this cloak toward

the sky, the satisfaction of completing this mahi provides spiritual fulfillment: We weave not only with harakeke, but with manawa, to ensure the shelter for our future generations.

The significance of this thesis to the realm of Hine-te-Iwaiwa is clear. It restores her to the centre of maternity and midwifery practice, re-establishing her teachings as constitutional, clinical, and spiritual law. Each chapter has enacted her presence: Chapter Two revived her cosmology; Chapter Three wove the ritual of rangahau; Chapter Four returned her voice through the kōrero of whānau; and Chapter Five offers her practical expression through reform. This way, the thesis itself becomes ceremony — a living whāriki that reunites the professional, political, and spiritual dimensions of care.

To honour Hine-te-Iwaiwa is to protect the future of whakapapa. When wairuatanga, tikanga, and mātauranga Māori guide maternity systems, birth becomes more than biological survival — it becomes whakawhanaungatanga between realms, a renewal of constitutional relationship between Māori and the Crown, and an affirmation that sovereignty begins in the womb. This rangahau contributes to that reclamation, showing that spiritual safety is clinical safety, and that the restoration of wairua is the restoration of justice.

Each recommendation translates her teachings into contemporary form—whānau-centred care as weaving, policy as thread, midwives as kaitiaki of the divine matrix. In restoring wairuatanga to the architecture of maternity care, the work re-establishes the sacred contract between people and cosmos: that every birth is ceremony, every policy a karakia, and every system a whāriki, upon which future generations will stand.

In this same spirit, Henry (2015) reminds us that te whare ako and marae are living embodiments of practical wisdom — places where heart, mind, and spirit converge in the act of learning. They are physical and spiritual architectures that nurture transformation. Like these spaces, this thesis becomes a whare ako in its own right: a place where wairua, whakapapa, and praxis are braided together, teaching and continuing the work of restoration.

This closing does not mark an ending, but the completion of one phase in a larger cycle—the waning of one marama before the rise of another (Marsden, 2003; Matamua, 2017). Knowledge, like water, returns to its ūkaipō, flowing between generations and back to its source (Hikuroa, 2016). The weaving continues, shifting into new hands, contexts, and new generations. The work of restoration is never finished; it moves in tides—passed from hand to hand, heart to heart, returning always to its source as an unbroken river of aroha and wairua.

Just as the Governor-General carries the delegated authority of the Crown, Hine-te-Iwaiwa carries the mandate of Io and the atua wāhine; she is a pou herenga atua — anchoring the lores of birth, rhythm, and restoration across generations. Thus, the significance of this

rangahau lies not only in its academic contribution but in its spiritual restitution — restoring Hine-te-Iwaiwa to her rightful place as the atua māngai o Te Whare Tangata, the living guardian of maternal wellbeing in Aotearoa.

The wānanga therefore closes not with finality, but with resonance — the echo of waiata and breath that continues long after words have ended. For me, that closing song is “Tai Aroha”, composed by papa Anaru and Hākopa Kupenga. Standing upon Hikurangi, facing the eastern horizon as the sun rises and the marama ascends, I feel gratitude, for those who have guided me, for whānau who held me, and for the atua and those before me, who breathed life into this work. I begin to sing, closing this kaupapa:

Ko te aroha anō he wai, E pupū ake ana,

He awa, e māpuna mai ana, I roto i te whatū-manawa,

(repeat)

Ko tōna mātāpuna he hōhonu, Ā inā ia ka rere anō,

(repeat)

He tai timu, he tai pari, he tai ope, he tai roa, he tai nui, he tai nui, he tai nui.

Aroha, like water, wells up and flows again — ebbing and returning as the tides: unending, life-giving, connecting all things.

Like the lyrics of this song, may this work flow outward—through whānau, wānanga, and future policy—and return as mauri renewed. Te Whāriki o Hine-te-Iwaiwa now lies upon the summit of Hikurangi, presented to Hine-rau-ma-Ukuuku, the weaver of regenerative knowledge, guardian of growth and wife of Maui (Tairāwhiti Trails, n.d.). True to my name, I put the whāriki into a Kupenga and cast it toward te marama, offering it to Hine-te-Iwaiwa, so that she may distribute it through the currents encircling Aotearoa and wider, to those ready to rise and continue the weaving.

Ina ka ora te wāhine, ka ora te hāpu, ka ora to whenua.

When women are in good health, the people and lands thrive.

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Appendix A: Approved ethics

Auckland University of Technology Ethics Committee (AUTEC)

22 October 2024

Deborah Heke
Faculty of Health and Environmental Sciences

Dear Deborah

Re Ethics Application: **24/41 Tapu i te wa hapū: Exploring the wairuatanga of Te Whare Tangata**

Thank you for your responses to AUTEC's conditions.

Your ethics application has been approved for three years until 21 October 2027.

Non-Standard Conditions of Approval

1. On the Consent Form, delete the statement regarding the storage of all study data at the research department at Ngati Porou Oranga, as this is inconsistent with the undertakings given in the body of the Information Sheet, and the Data Management Plan.

Non-standard conditions do not need to be submitted to or reviewed by AUTEC unless requested but must be completed before commencing your study.

Standard Conditions of Approval

1. The research is to be undertaken in accordance with the Auckland University of Technology Code of Conduct for Research and as approved by AUTEC.
2. All public facing documents must have the AUTEC approval number and be of a high standard of spelling and grammar. Dates on the Information Sheet(s) and Consent Form(s) must be consistent.
3. Any amendments to the project must be approved by AUTEC prior to being implemented.
4. A progress report is due annually on the anniversary of the approval date.
5. A final report is due at the expiration of the approval period, or, upon completion of project.
6. Any serious or adverse events must be reported to AUTEC, this includes unforeseen issues that might affect continued ethical acceptability of the project.
7. AUTEC grants ethical approval only. You are responsible for obtaining management permission for access from any institution or organisation at which your research is being conducted and you need to meet all ethical, legal, public health, and locality obligations or requirements for the jurisdictions in which the research is being undertaken.

The application number and title need to be referenced on all correspondence related to this project.

All forms are available online http://www.aut.ac.nz/research/researchethics

For any enquiries, please contact the Secretariat at ethics@aut.ac.nz
(This is a computer-generated letter for which no signature is required)

The AUTEC Secretariat
Auckland University of Technology Ethics Committee

Cc: Kaniwathemidwife@hotmail.com

Auckland University of Technology, D-88, Private Bag 92006, Auckland 1142, New Zealand.
T: +64 9 921 9999 ext. 8316: E: ethics@aut.ac.nz: www.aut.ac.nz/researchethics

Appendix B: Research pānui

Abstract/Summary:

AIM: Wairuatanga has often been overlooked in healthcare and has been denigrated by medical models of health care, including maternity care. Exploring the wairuatanga of wāhine Māori as te whare tangata through a Māori-centered approach will provide an in-depth understanding of indigenous spirituality and the impact it holds in the holistic wellbeing of wāhine, their pēpi and whānau.

BACKGROUND: Wāhine Māori continue to experience persistent health inequities within the maternity system of Aotearoa New Zealand. As the leading ethnic group that experiences spontaneous births and represents just over a quarter of the birthing population, we are legislatively bound by Te Tiriti o Waitangi to address and rectify these inequities. 93% of women are cared for by Lead Maternity Carers, who are registered midwives, and are trained under a holistic philosophy of care, yet our holistic aspects of care are unclear beyond integrating body and mind practice paradigms. Most importantly, the voice of wāhine Māori and whānau are missing from informing practitioners, what else is included beyond body and mind or what constitutes the spiritual aspects of health care for maternity.

METHODOLOGY: Kaupapa Māori centered research, informed by a mana wahine theoretical approach and thematic analysis of data.

METHODS: Wānanga is a kaupapa Māori way of conducting group interviews. Hosting a wānanga enables the researcher to conduct group interviews to collect information from participating whānau, with all marae tikanga being followed. A minimum of ten and a maximum of fifteen whānau will be recruited, with each participating whānau member assigned to one of five categories; wahine, tane, kuia, kaumatua; or maternity kaimahi. Every category that whānau identify with will be able to attend the wānanga, which will collect data via AUDIO recorded semi-structured interviews. Whānau must be aged eighteen years or older and complete a consent form to participate in the wānanga. Tamariki are not excluded from attending the wānanga but will not have data collected from them to include in this research. Individual interviews will only be conducted with those who are unable to attend the wānanga AND I have not met my minimum recruitment goal.

SIGNIFICANCE: As a Māori midwife, māmā and matriarch, I am passionate in sharing mātauranga with whānau about holistic wellbeing, and how to achieve it with a focus on our future mokopuna. To this end, I will explore the spiritual significance and connections to the origins of life through hapū māmā, their vital role as te whare tangata and being architects of their whakapapa. I seek to contribute to the growing knowledge of epigenetics and population health from an indigenous perspective.

Kaniwa Kupenga-Tamarama;

Te Whānau a Ruataupare, Te Aitanga a Mate, Te Whānau a Rakairoa,
Ngati Apakura, Ngati Hikairoa

Is a Māori Midwife and māmā of 5 tamāriki. A proud member ot the Ngāti Uepohatu Branch of the Māori Women's Welfare League, He Hono Wāhine and Chairwoman of Te Wakahuia o Hine.

Kaniwa embarks upon her master's journey with AUT University, exploring the wairuatanga of te whare tangata during childbirth.

She is seeking 10-15 participants to host in Marae based wānanga and conduct group interviews to gather whānau mātauranga to tautoko the creation of the thesis titled' Tapu i te wa hapū.

For more information, please contact Kaniwa on:
kaniwathemidwife@hotmail.com

Supervisor: Deborah Heke on
deborah.heke@aut.ac.nz

Appendix C: Information sheet

Patient information sheet

Project title:	***Tapu i te wa hapū: Exploring the wairuatanga of te whare tangata.***
Project Supervisor:	***Dr Deborah Heke***
Researcher:	***Kaniwa Kupenga-Tamarama***
Study site:	***Tairāwhiti***
Contact number:	*02102891937*

Ethics committee Reference: 24/41

You are invited to take part in a study on **exploring the wairuatanga of te whare tangata**. Whether or not you take part is your choice. If you don't want to take part, you don't have to give a reason. If you do want to take part now, but change your mind later, you can pull out of the study at any time.

This Participant Information Sheet will help you decide if you'd like to take part. It sets out why we are doing the study, what your participation would involve, what the benefits and risks to you might be, and what would happen after the study ends. We will go through this information with you and answer any questions you may have. Before you decide, you may want to talk about the study with other people, such as whānau, friends, or healthcare providers. Feel free to do this.

If you agree to take part in this study, you will be asked to sign the Consent Form on the last page of this document. You will be given a copy of both the **Participant Information Sheet** and the **Consent Forms to keep**. This document is 7 pages long, including the Consent Forms. Please make sure you have read and understood all the pages and fill out the consent form. It is your choice to withdraw from this study at any given time prior to the information being de-identified and coded. After your contribution has gone through the process of it being de-identified and coded, it will be very difficult to identify your contributions and remove them. Please consider carefully your participation and feel free to talk to your whānau, before you provide any completed consent forms.

What is the purpose of the study?

Wāhine Māori continue to experience persistent health inequities within the maternity system of Aotearoa New Zealand. As the leading ethnic group that experiences spontaneous births and represents just over a quarter of the birthing population, we (health professionals) are legislatively bound by Te Tiriti o Waitangi to address and rectify these inequities. 93% of women are cared for by Lead Maternity Carers, who are registered midwives, who are trained under a holistic philosophy of care, yet our holistic aspects of care are unclear beyond integrating body and mind practice paradigms. Most importantly, the voice of wāhine Māori and whānau are missing from informing practitioners, what else is included beyond body and mind or what constitutes the spiritual aspects of health care for maternity.

Wairuatanga has often been overlooked in healthcare and has been denigrated by medical models of health care, including maternity care. Exploring the wairuatanga of wāhine Māori as Te Whare Tangata through a Māori-centered approach will provide an in-depth understanding of indigenous spirituality and the impact it holds in the holistic wellbeing of wāhine, their pēpi and whānau.

I am undertaking this research as I am passionate about our whakapapa and ensuring the continued reclamation of our tikanga around childbirth. By completing this research, I will gain a master's degree in health science.

How is the study designed?

This study is a kaupapa Māori centered designed research, informed by a Mana wahine theoretical approach and thematic analysis of data.

Wānanga is a Kaupapa Māori way of conducting group interviews. Hosting a wānanga enables the researcher to conduct group interviews to collect audible information from participating whānau, with all marae tikanga being followed. Individual interviews will only be conducted with whānau members who are unable to attend the wānanga and if I have not met my minimum recruitment goal of 10 participants.

Who can take part in the study?

A minimum of ten and a maximum of fifteen whānau will be recruited, with each participating whānau member assigned to one of four categories; wahine, tane (not yet given birth or become a parent); wahine, tane and tamariki (have given birth and raised tamariki); kuia and kaumatua; or maternity kaimahi. Every category that whānau identify with will be able to attend the wānanga, which will collect data via **audio recorded** semi-structured focus group interviews. Whānau must be aged eighteen or older and complete a consent form to participate in the wānanga. Tamariki are not excluded from attending the wānanga but will not have data collected from them to include in this research.

What will my participation in the study involve?

To participate in this study, will require you to attend the research wānanga commencing with a karakia timatanga at 9am on Saturday 25th January 2025, until karakia whakamutunga at 3.00pm the same day. A powhiri will be held, Friday 24th January 2025, 3pm.

Whānau participating will be part of a wānanga that will partake in focus group interviews.You may deem some of the questions sensitive, as it recalls memories and experiences that are painful when sharing.

I will be using an audio recorder to record wānanga to assist data collection, to ensure that I do not miss shared kōrero when facilitating the research wānanga. I will be re-listening to audio recordings of the wānanga to assist in data analysis. Once I have finished collecting and analysing data, I will be electronically sending all physical copies to my AUT supervisor Dr Deborah Heke, to upload for secure, storage for a minimum of six years after the publication of this thesis (as per legislative requirements).

What are the possible risks of this study?

Due to the impacts of colonisation and the migration away from traditional birthing practices, whānau participating may share experiences where they feel very emotional about their birthing experiences and how it impacted upon them, both negatively and positively. We will have kaumatua present to ensure that all whānau participating, their holistic wellbeing is maintained.

WHAT ARE THE POSSIBLE BENEFITS OF THIS STUDY?

Participating in this study will contribute to 'what the wairuatanga aspects of care' are and how they can be applied to hapū wāhine Māori, Māori whānau giving birth and caring for whānau Māori after birth. Thus, providing wāhine Māori, whānau Māori and professionals whom care for wāhine Māori during hapūtanga, birth and the period after birth, insight into what the wairuatanga aspects are when caring for te whare tangata.

This work will contribute to the growing body of knowledge of indigenous maternal practices and population health from an epigenetic and population health perspective.

Will any costs be reimbursed?

Participating in this research wānanga, will provide participants an opportunity to spend time at Te Aowera Marae with accommodation costs covered and catering provided. Participating whānau will be presented with a koha in appreciation of their time.

De-identified (Coded) Information

To make sure your personal information is kept confidential, information that identifies you will not be included in any report generated by the researcher AND/OR any study information sent to AUT University. Your name will be changed to a pseudonym unless you give specific instructions to publish your real name. The researcher will keep a list linking your pseudonym name with your real name, so that you can be identified by your coded data if needed. This

The results of the study may be published or presented, but not in a form that would reasonably be expected to identify you.

Future Research Using Your Information.

If you agree, your coded information may be used for future research related to indigenous maternal spirituality, holistic wellbeing during the first 2000 days of development of a child and maternal holistic wellbeing and population health. Your direct consent will be requested before any future research opportunities are commenced.

This future research may be conducted overseas. You will not be told when future research is undertaken using your de-identified and coded information. Your information may be shared widely with other researchers or companies.

Your information may also be added to information from other studies, to form much larger sets of data.

You **will not** get reports or other information about any / some research that is done using your information.

Your information may be used indefinitely for future research unless you withdraw your consent. However, it may be extremely difficult or impossible to access your information or withdraw consent for its use once your information has been shared for future research.

Security and Storage of Your Information.

Your identifiable information is held securely physically in a locked metal filing cabinet with the supervisor (Dr Deborah Heke) during the study. After the study it is transferred to a secure archiving site at AUT University and stored for at least **six years**, then destroyed. Your coded information will be entered into electronic case report forms and sent through a secure server to the AUT University. Coded study information will be kept by AUT University in secure, cloud-based storage indefinitely. All storage will comply with local data security guidelines.

Risks.

Although efforts will be made to protect your privacy, absolute confidentiality of your information cannot be guaranteed. Even with coded and anonymised information, there is no guarantee that you cannot be identified. The risk of people accessing and misusing your information (e.g. making it harder for you to get or keep a job or health insurance) is currently very small but may increase in the future as people find new ways of tracing information.

This research includes basic information such as your ethnic group, geographic region, age range, and sex. It is possible that this research could one day help people in the same groups as you.

However, it is also possible that research findings could be used inappropriately to support negative stereotypes, stigmatize, or discriminate against members of the same groups as you by others.

Rights to Access Your Information.

You have the right to request access to your information held by the research team. You also have the right to request that any information you disagree with is corrected.

If you have any questions about the collection and use of information about you, you should ask researcher.

Rights to Withdraw Your Information.

You may withdraw your consent for the collection and use of your information at any time, by informing Kaniwa Kupenga-Tamarama (Researcher).

If you withdraw your consent, your study participation will end, and the study team will stop collecting information from you.

If you agree, information collected up until your withdrawal from the study will continue to be used and included in the study. You may ask for it to be deleted when you withdraw unless you withdraw after the study analyses have been undertaken.

Ownership Rights.

Information from this study may lead to the development of a commercial product. The rights to these will belong to the researcher. You and your family will not receive any financial benefits or compensation, nor have any rights in any developments, inventions, or other discoveries that might come from this information.

CAN I FIND OUT THE RESULTS OF THE STUDY?

To celebrate Matariki in 2025, I will send all wānanga participants an invitation to join me online, to present to them my research findings and share with them the final draft thesis to review before being submitted and published. I will share updates on my social media pages and/or website "Kia Kaha Māmā".

WHO IS FUNDING THE STUDY?

I have gained financial support from the New Zealand College of Midwives to pay for my university tuition fees totalling $10,441.64. I have also gained $2000.00 from Te Runanga o Ngati Porou nui - Toitū postgraduate funding in 2024. I will be applying for scholarships to assist in additional costs associated with the research wānanga and facilitation.

WHO HAS APPROVED THE STUDY?

This study has been approved by the AUT University postgraduate research board, AUT University Ethics approval committee.

Who do I contact for more information or if I have concerns?

Name: Kaniwa Kupenga-Tamarama

Position: Masters of Health Science Student, Primary Researcher

Telephone number: 021 028 91937

Email: Kaniwathemidwife@hotmail.com

You can also contact Kaniwa's supervisor; Dr Deborah Heke

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Appendix D: Consent form

Consent Form

Project title: ***Tapu i te wa hapū: Exploring the wairuatanga of te whare tangata***

Project Supervisor: ***Dr Deborah Heke***

Researcher: ***Kaniwa Kupenga-Tamarama***

- ○ I have read and understood the information provided about this research project in the Information Sheet dated **14 October 2024.**
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that notes will be taken during the interviews and that there will also be audio-taped recorded and transcribed.
- ○ I understand that identity of my fellow participants and our discussions in the wānanga is confidential to the group and I agree to keep this information confidential.
- ○ I understand that notes will be taken during the focus group and that it will also audio recorded and transcribed.
- ○ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- ○ I understand that if I withdraw from the study then, while it may not be possible to destroy all records of the wānanga discussion of which I was part, I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- ○ I agree to my information being de-identified and coded to protect my privacy.
- ○ I agree that my de-identified and coded information may be used in future research related to indigenous maternal spirituality, holistic wellbeing during the first 2000 days of development of a child and maternal holistic wellbeing and population health.
- ○ I agree to have all recorded data from this research wānanga to be securely cared for by AUT University. This includes the consent forms, audio taken, transcribed documentation and data analysis interpretation.
- ○ I agree to take part in this research.
- ○ I wish to receive a summary of the research findings (please tick one): Ae ○ Kao ○

Participant's name:.....

Participant's:
signature :.....

Participant's Contact Details (if appropriate): Date :

.....

Approved by the Auckland University of Technology Ethics Committee on 22nd October 2024
AUTEC Reference number 24/41

Appendix E: Summary of Social Media Analytics

Purpose:

Appendix E documents a summary of verified social media analytics gathered from Meta Business Suite, Instagram Insights, and LinkedIn Analytics. These data supported participant recruitment and dissemination of the research pānui for Tapu i te wā hapū: Exploring the wairuatanga of Te Whare Tangata.

All raw screenshots and participant interactions are securely stored by the researcher but are not reproduced in this thesis to uphold privacy and ethical integrity.

Note on Data Source:

The Facebook (Kia Kaha Māmā) and Instagram (@kia_kaha_mama) analytics are reported through a single Meta Business Suite dashboard. As these platforms are interconnected, metrics such as reach, views, and engagement partially overlap. The figures presented therefore represent combined performance across both channels rather than distinct totals for each.

Table E: Platform Summary.

Platform	Account / Page	Period	Key Metrics	Engagement Highlights	Audience Insights
Facebook	Kia Kaha Māmā	9–10 Nov 2024	1,129 reach / 1,579 video views / 3 likes / 2 new followers	Majority engagement from wāhine aged 25–44	Audience 91% wāhine; strong East Coast and Tairāwhiti reach
	Hiruharama Marae Page	11 Dec 2024	34 reactions / 9 comments	Participant interest and confirmation via comments	Whānau and hapū-based networks
	Te Aowera Marae Page	12 Dec 2024	13 reactions	Re-shares through whakapapa links	Ngati Porou and Tairāwhiti-based reach
Instagram	@kia_kaha_mama	9–10 Nov 2024	1,579 views / 1,129 accounts reached	New followers, DMs of tautoko and interest	Audience primarily Māori wāhine and māmā
LinkedIn	Kaniwa Kupenga-Tamarama	11 Nov 2024	346 impressions / 104 members reached /	Repost by *Women's Health Action Trust*	Engagement from midwifery and health professionals

			14 reactions / 1 comment / 1 repost		

Ethical Considerations:

Analytics were documented via screenshots but not reproduced in the thesis due to identifiable information in comment threads and profile interactions. Data have been retained in the researcher's secure, password-protected archive as per AUT Ethics approval (24/41). All online engagement was treated as relational data — prioritising whakawhanaungatanga and manaakitanga over metrics alone.

Summary Interpretation:

Across all platforms, the combined reach exceeded 2,600 individuals, with over 1,600 direct views and multiple private messages or kanohi-ki-te-kanohi follow-ups. These engagements demonstrated that kaupapa-aligned social media can serve as a digital karanga — a spiritually resonant call inviting those aligned with the kaupapa to step forward in their own time and manner.

Appendix F: Semi structured research questions

Semi-structured focus group questions

for research wānanga

1. What entails the wairua (spiritual) dimensions of wāhine Māori as te whare tangata?

2. How does a lack of wairua care affect wāhine Māori as te whare tangata?

3. What are the long-term effects of receiving care that does not value or incorporate the dimension of wairuatanga (spirituality) surrounding procreation?

4. Why is wairua awareness, education and care an important aspect to health care in reducing maternal and child health inequities?

5. Explain what wairuatanga means to you as a wahine /tāne / Kuia / Kaumatua Māori?

6. Can you please explain what wairuatanga of te whare tangata means to you and your whānau?

7. What has your whānau, school or professionals taught you about the sacredness of te whare tangata?

8. What has your whānau, school or professionals taught you about te whare tangata and the ability to procreate life?

9. What is the role of wahine regarding maintaining the wellbeing of te whare tangata?

. What is the role of tāne regarding maintaining the wellbeing of te whare tangata?

. What is the role of whānau/hapū/iwi regarding maintaining the wellbeing of te whare tangata?

. What is the role of professionals regarding maintaining the wellbeing of te whare tangata?

10. Have you experienced care that has included caring for your wairua as a hapū wāhine, birthing māmā, post-birth māmā or whānau member of a wāhine who is going through whakawhānau (birthing)?

. Can you describe how it was included and how that impacted upon your wairua?

. Can you describe how it was not included and how that impacted upon your wairua?

11. Have you reclaimed any traditional mātauranga and included it into your whānau tikanga around whakawhānau? (childbirth).

. If so, what? Please describe how you included it and how that impacted upon the collective wairuatanga wellbeing of your whānau.

12. How does including the care of wairua impact upon the wahine, pepi and whānau?

13. How does including the care of wairua impact upon the community and tribal wellbeing?

Appendix G: Thematic Analysis Summary

This appendix presents the key analytic stages used to develop the thematic findings for Tapu i te wā hapū: Exploring the wairuatanga of Te Whare Tangata. The tables summarise (1) the intermediate phase where codes were clustered into sub-themes, and (2) the final thematic framework that informed the presentation of findings in Chapter Four. Full raw coding data are retained in the researcher's secure archive and are not published for confidentiality reasons.

Table G.1. Intermediate coding and theme development

Preliminary Theme	Sub-themes / Pattern Codes	Description or Analytical Note
Reclaiming Wairuatanga in Birth	Loss through colonisation, Resurgence through practice, Spiritual embodiment of birth.	Participants described birth as a site of both rupture and renewal, linking personal transformation to collective reclamation.
Te Whare Tangata as Cosmology	Sacredness of the womb, Whakapapa continuum, Hinengaro-wairua connection.	The body was viewed as a portal between realms, where atua wāhine guide creation.
Midwives as Wairua Holders	Presence, Karakia, Holding mauri in clinical spaces.	Midwives were seen as spiritual custodians rather than biomedical technicians.
Whakapapa and Intergenerational Healing	Honouring ancestors, Healing trauma, Cycles of reconnection.	Whānau stories revealed healing that extended beyond the individual.
Whānau Voice and Collective Care	Shared learning, Community strength, Wānanga as practice.	Birth was discussed as a collective act of learning and restoration.

Appendix G, Table 1 shows how initial codes were clustered into coherent conceptual patterns prior to final theme confirmation.

Table G.2. Final thematic framework model (Braun & Clark, 2021).

Overarching Theme	Sub-themes	Illustrative Quote	Interpretive Insight

1. Disconnection and Reclamation of Wairuatanga in Birth.	Colonisation and spiritual rupture, Returning to ceremony, Birthing as decolonising act.	“I just looked at it as the portal to other dimensions that brings life into this reality — turning wairua into tinana into the physical. And what’s more sacred than that?”	Birth is recognised as a cosmological act where wairua takes form, restoring sacred knowledge lost through colonisation.
2. Te Whare Tangata and the Sacredness of the Wāhine Body.	The womb as cosmic space, Atua wāhine embodiment, Maramataka rhythms	“Our bodies aren’t just bodies; they’re tapu. They carry whakapapa, they carry atua, they carry futures.”	The wāhine body is framed as Te Whare Tangata — a vessel of intergenerational life, divine presence, and cosmological continuity.
3. Midwifery as Ritual, Witness, and Wairua Holding.	Karakia in practice, Spiritual safety, Tohunga-like roles.	“She asked me about my pepeha before anything else — before talking about the birth plan or pain or anything. It was like she needed to know who I was before she touched me.”	Māori midwives act as spiritual anchors, establishing relational and whakapapa connection before clinical care, reaffirming birth as sacred encounter.
4. Whakapapa, Atua, and Intergenerational Healing.	Healing trauma through connection, Calling on ancestors, Whānau continuum.	“When we carry trauma and we don’t heal it, it doesn’t just stay in us. It moves through us — our tamariki carry it too.”	Participants describe birth as healing ancestral wounds and transforming whakapapa through conscious connection to atuatanga.

5. Whānau Ora, Collective Voice, and the Power of Wānanga.	Whānau leadership, Wānanga learning, Community solidarity.	“Imagine if we were able to just do this all the time … I would have walked out those doors thinking ‘holy shit, I’m magical … I can be a game changer now.’	Wānanga experiences revived collective confidence and mana, showing how knowledge sharing becomes transformative for whānau and iwi.

Analytic Summary:

This thematic analysis demonstrates how participant kōrero were interpreted through a kaupapa Māori, wairua-centred lens. The process moved from inductive coding to pattern recognition and thematic synthesis, guided by Braun & Clarke’s (2021) reflexive model. The resulting framework underpins the findings presented in Chapter Four, where each theme is expanded through narrative, participant voice, and theoretical reflection.

Ethical Note:

All participant quotes are presented in anonymised form, in accordance with AUT Ethics approval 24/41. Full transcripts and raw coding data are securely stored by the researcher and will not be publicly released.

Appendix H: Transcriber Confidentiality Agreement

Confidentiality Agreement

For someone transcribing data, e.g. audio-tapes of interviews.

Project title:	*Tapu i te wa hapū: Exploring the wairuatanga of te whare tangata.*
Project Supervisor:	*Deborah Heke & Kirsten Gabel*
Researcher:	*Kaniwa Kupenga-Tamarama*

- ○ I understand that all the material I will be asked to transcribe is confidential.
- ○ I understand that the contents of the tapes or recordings can only be discussed with the researchers.
- ○ I will not keep any copies of the transcripts nor allow third parties access to them.
- ○ I will not share any aspects of what I hear or transcribe with anyone other than the researcher or supervisors of this research.

Transcriber's signature: .....

Transcriber's name: .....

Transcriber's Contact Details (if appropriate):

.....

.....

.....

.....

Date:

Project Supervisor's Contact Details (if appropriate):

Dr Deborah Heke: 027 225 3779

Kirsten Gabel: kirsten.gabel@aut.ac.nz

Approved by the Auckland University of Technology Ethics Committee on 22 October 2024 AUTEC Reference number 24/41

Note: The Transcriber should retain a copy of this form.

April 2018 page 1 of 1 This version was last edited in April 2018

Appendix I: Glossary

Notes on Language / Use of Te Reo Māori

Throughout this thesis, I have intentionally included as much kupu Māori as possible to reflect the kaupapa, worldview, and language from which this research emerges. The kupu used are primarily those of the dialects I have been exposed to — most commonly Ngāti Porou — though along my journey I have also drawn from the diverse dialects of te reo Māori found across Aotearoa and within reputable online Māori dictionaries.

As a wāhine Māori whose first language is English, my journey to repatriate te reo into my own whānau has deepened my understanding that my reo does not need to be visually marked as other. Each kupu I write is a reclamation — a return of what has always been mine.

Growing up also as a “Kiwi”, I naturally move between te reo Māori and English in the same breath. This thesis is no different. Although it is an academic representation of my work, it is also a reflection of me — my voice, my whakapapa, and my ongoing journey of linguistic and cultural reconnection. I have tried to write as if I am speaking with you, not to you, allowing the language to breathe as it does in everyday life.

Te Reo	English
Ātea, ātea	To be clear of restrictions, courtyard
Ahurangi	Healing alter
Amaia	Lunar rainbow
Aniwaniwa	Rainbow
Aotearoa	New Zealand
Āria	Pathway
Ara	Emblem of god/goddess
Aroha	Love
Ātaahua	Beautiful
Atua	God/Goddess
Awa	River
Awatea	Dawn, sunrise
Hā	Breath
Haerenga	Journey
Hangahanga	Structure
Hangi, Hāngi	Earth oven, earth cooked food.

Hāpu	Subtribe
Hapū, hapūtanga	Pregnant, Pregnancy, Antenatal
Harakeke	Flax
Haukainga	Family keeping the home fires burning
Haumia	God of Peace
He Hono Wahine	Māori Obstetricians and Gynaecologists collective
Herenga	Commitment
Hikurangi	To pull up
Hinengaro	Mind
Hine-nui-te-po	Goddess of death, underworld
Hine-te-Iwaiwa	Goddess of Childbirth, Moon cycles, weaving and women's rights
Hine-titama	First woman
Hiruharama	Jerusalem
Hoahoa	Design
Iho, iho matua	Cord, umbilical cord of spiritual energy
Ikura	Menstruation
Io	God
Iwi	Tribe, people
Kahu Taurima	Maternity and Early Years Government Health portfolio
Kai	Food
Kaiawhina	Carer
Kainga, kāinga	Home
Kaitā	Traditional tattoer
Kaitiaki	Guardian
Kaituhi	Writer
Kārearea	Native hawk
Kawakawa	Plant - Macropiper excelsum
Kawanatanga	Government
Kanohi	Face

Karakia	Pray
Karanga	Traditional spiritual call
Kaumatua	Elders
Kaupapa	Subject/topic
Kaupapa Māori	Māori way's of doing things, by Māori, for Māori.
Kererū	Native wood pigeon
Kete	Basket
Kiwi	Flightless Bird, Person identifying as a New Zealander
Koha	Gift
Kōhanga Reo	Language nest, Māori pre-school
Kōhine, kohine, hine	Girl
Kōrero	Speak/conversation
Kuia	Female elder, grandmother
Kupenga	Woven fishing net
Kupu	Word
Mahi, kaimahi	Work, worker
Mahara	Remember
Mahau	Front porch of wharenui
Māmā	Mother
Mana	Inherited status
Manakitanga	Care, uplift, kindness
Mana motuhake	Autonomy, sovereignty
Manawa	Heart
Mana wahine	Māori feminism
Māngai	Mouth, spokeperson
Māori	Indigenous person of New Zealand
Marae	Tribal house
Marama, hina	Moon, enlightenment, understand
Maramataka	Phases of the moon, lunar calendar
Matariki, Matāriki	Pleides constellation
Matatika	Ethics, straight

Matauranga, Mātauranga	Knowledge
Maui	A deity of the pacific
Maunga	Mountain
Mauri, mauritau	Life essence, relaxed
Mirimiri	Soft tissue massage
Moana	Ocean
Mokemoke	Lonely, isolated
Moko Kauae	Tattooed chin (traditional female markings)
Mokopuna	Grandchild
Moteatea	Traditional Chant
Muka	Inner white fibres of Flax
Nehu	Burial
Ngati Porou	Tribe of the East Coast of the North Island
Ngati Porou Oranga	Tribal Health Provider
Nga, Ngā	Many
Ngā Maia o Aotearoa me te Waipounamu, Ngā Maia o Aotearoa, Ngā Maia Trust	Māori Midwives Collective
Ora, Oranga	Life, Wellbeing
Ōritetanga	Equality
Oriori	Traditional lullaby
Otinga	Completion, conclusion, end
Pākeha	Non-Māori (from a village that travels/sails in wind).
Papa, Pāpa/ Koro	Father, Grandfather, male elder ≥ generations above
Papatūānuku	Mother Earth
Panipani	To spread, cosmetics, herbal infused balm
Pātai	Question
Pēpi	Baby
Pōhutukawa	Native tree, star within Pleides.
Pono	True
Poroporoaki	Last feast, closing ritual

Poutama	Ascending pathway to higher learning/ pattern
Pōtiki	Youngest
Pōwhiri	Cultural ceremony of connection
Pou	Pole, support
Poukai	King movement gathering
Puku	Stomach, belly
Pu-te-Hue	God of nourishment
Pūmanawa	Lower puku, intuitive core, ancestral creativity
Pūmotomoto	Anterior fontanelle
Pūrakau	Story
Pure	Cleansing, releasing
Rākaunui	Full moon
Rangahau	Research
Rangatira, Rangatiratanga	Leader, Leadership
Rangi Tūhāhā	Heaven realm
Rangona	Sound, heard
Raranga	Weave, weaving
Rehua	Spiritual guardian of the 12th heavenly realm
Ringarehe	Accomplished, skilled, proficient
Romiromi	Traditional deep tissue massage
Rongo	God of Cultivated food
Rongoā	Māori healing arts, healing philosophy
Roto	Internal, inside
Taha	Side
Taiao	Environment
Tairāwhiti	East Coast of the North Island
Taitama	Boy
Tamaiti, tamariki	Children
Tāmaki Makaurau	Auckland
Tane, Tāne	Man, men
Tangaroa	God of the Ocean
Tangata	Person

Tangi, Tangihanga	Cry, funeral
Taonga-a-waha	Sacred oral traditions
Taonga pūoro	Sacred sound – flute instrument
Tapu	Sacred
Tapu i te wā hapū	Sacred through pregnancy
Taramainuku	Guardian of collecting spirits and transporting them to Matariki
Tātari	Wait
Tautoko	Support
Tautoru	Orion's Belt
Tāwhirimatea	God of Wind
Te Aho Matua	Kura Kaupapa Māori Education Curriculum
Te Ao	The world
Te Aka Whai Ora	Māori Health Authority
Te Ira Atua	The divine spark or gods
Te Moana-nui-a-Kiwa	Pacific Ocean
Te Po	The night
Te Reo	Māori language
Te Rerenga Wairua	Spiritual pathway to underworld
Te Tiriti o Waitangi	The Treaty of Waitangi
Te Wakahuia o Hine	The sacred vessel of her, Māori maternal & infant wellbeing organisation
Te Whare Pora	The house of night & day/ House of weaving & learning
Te Whare Tangata	The house of humanity/ womb
Te Whāriki o Hine-te-Iwaiwa	The mat of the goddess of childbirth, framework for this study
Teina	Younger sibling, same sex
Tika	Right
Tikanga	Practice/policy
Timatanga	Start, commence, beginning
Tinana	Body
Tino	Very good, very great
Tohu	Sign

Tohunga, tohuna	Spiritual healer
Tōhua	Unborn developing baby/ fetus
Topenga	Cut, severe
Tuakana	Older sibling, same sex
Tuhinga	Thesis, writing
Tūhoe	Tribal people from the Urewera
Tukutuku	Board, panel (for art work)
Tūmatauenga	God of War
Tūpuna, Tipuna	Ancestors
Tūranga Kaupapa	Midwifery cultural safety standards and programme
Tūranganui-a-Kiwa	Gisborne
Tūrangawaewae	Standing place of uplift
Ūkaipō, Ūkaipōtanga	Breastfeeding
Wahakura	Safe sleeping woven basket for pēpi
Wahine, Wāhine, wahinetanga	Woman, women, woman-hood
Wai, Wairākau	Water, water infused plant tonic.
Waiariki	Sacred (healing) waters
Waiata	Song
Wairua, wairuatanga	Spirit, Spirituality
Waiū, whāngai ū	Breast, breastmilk, donated breastmilk
Waka	Canoe, vessel, car
Wānanga	Learning space
Whakahoki	Returning
Whakakapi	Closing/finishing
Whakamutunga	Finished
Whanake	To move onwards, to move upwards
Whāngai, whāngaiahia	Traditional adoption, raised by other family, nuture
Whakanoa	To return balance, remove restrictions
Whakapapa	Geneaology
Whakawhanau	Birth, birthing
Whakawhanaungatanga	Finding connection with one another

Whakawhetai	Gratitude
Whakawhiti	Exchange
Whanaungatanga	Connection, distant relative
Whānau, whānui	Family, extended family
Wharekai	Eating house
Whare, Wharenui	House, Big house
Whāriki	Mat
Whatu, whātu	Eye, sight
Whatumanawa	Spiritual heart, seat of emotions, kidney
Whenua	Land, Placenta
Wharekai	Eating house